STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495093	A. BUILDING _____ B. WING _____	C 05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISONBURG HLTH & REHAB CNTR	1225 RESERVOIR STREET HARRISONBURG, VA 22801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 4/30/19 through 5/2/19. Corrections are required for substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
E 041 SS=E	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement	E 041		6/4/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/22/2019

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E 041	Continued From page 1	E 041		

the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.

482.15(e)(3), §483.73(e)(3), §485.625(e)(3)
Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.

*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):]
The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.
If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.
(1) National Fire Protection Association, 1 Batterymarch Park,
Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.
(i) NFPA 99, Health Care Facilities Code, 2012

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E 041	Continued From page 2 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by: Based on facility document review and staff interview, the facility staff failed to perform inspections and testing of the facility's emergency power generators as required in their emergency preparedness procedures. For six months, the facility failed to perform weekly inspections and monthly load testing on the facility's two emergency generators. The findings include: On 5/2/19 at 11:00 a.m., the facility's emergency preparedness policies were reviewed. The policy titled Emergency Generator (revised 4/23/19) documented, "All generator unit (s) are inspected weekly under a partial load including the transfer switch with a minimum generator run time of thirty	E 041	The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain incompliance with all state and federal regulations, the center has taken or will take the actions set forth in this Plan of Correction. In addition, the following plan constitutes the center□s allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated. E041 Weekly and monthly test have been	

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E 041	Continued From page 3 (30) minutes. Tests are documented and reviewed to assure maximum reliability...All generator units are tested monthly for at least thirty (30) minutes under a dynamic load..." On 5/2/19 at 11:45 a.m., the facility's generator testing and maintenance documentation was requested from the maintenance director. The maintenance records documented the facility had two generators for emergency power. The records revealed no weekly partial load or reliability inspections or monthly full loading testing on either generator from July 2018 through December 2018. A monthly full load test/weekly inspection was documented on 6/13/18. The next full load/weekly inspection was not performed until 1/28/19. On 5/2/19 at 11:45 a.m., the maintenance director was interviewed about the missing inspections/testing. The maintenance director stated when he first started working (June 2018) he did not know he was supposed to be testing/checking the generators. The maintenance director stated the generators start up "automatically" every week but he was supposed to check pressures and fuel levels to ensure reliability in case of an emergency. The maintenance director stated once a month, the generator was supposed to be tested under "full load" to be sure it provided adequate power. The maintenance director stated he did not find out he was supposed to perform testing and inspections until January 2019. The maintenance director stated the inspections and testing were not done for six months (July 2018 through December 2018). On 5/2/19 at 2:20 p.m., the administrator was	E 041	conducted on both generators and will continue to be performed to meet the Emergency Plan requirements. The Maintenance Director will report the test results to the Administrator during the Weekly 15 minute Departmental Meeting. Weekly and Monthly Generator testing has been added to the Electronic Preventive Maintenance program. All test will be reported at the Quarterly Quality Assurance meetings.	

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E 041	Continued From page 4 interviewed about the missing inspections/testing. The administrator stated the maintenance director was "new" in June 2018 and he did not know about the required testing/inspections. The administrator stated the maintenance director was not immediately trained on the generator inspections and maintenance requirements. This finding was reviewed with the administrator and director of nursing during a meeting on 5/2/19 at 12:20 p.m.	E 041		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 04/30/2019 through 05/02/2019. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Three (3) complaints were investigated during the survey. The census in this 180 bed facility was 174 at the time of the survey. The survey sample consisted of thirty-four (34) current resident reviews and four (4) closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that	F 550		6/4/19

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F 550	Continued From page 5 promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on resident interview and group interview, the facility staff failed to provide a dignified dining experience on the evening shift. Resident #59 and residents in a group interview stated that the facility staff stood over them on the 3-11 shift to "hurry" them through their evening meal.	F 550	F 550 Resident #59 informed and has been notified that his right to have a dignified dining experienced and not feel rushed will be abided by.	

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F 550	Continued From page 6 Findings were: Resident #59 was most recently admitted to the facility on 11/09/2018 with the following diagnoses, but not limited to: Bipolar disorder, chronic respiratory failure, Morbid obesity, hypertension and chronic respiratory failure. The MDS (minimum data set) in place at the time of the allegation was an admission MDS with an ARD (assessment reference date) of 11/09/2018, assessed Resident #59 as cognitively intact with a cognitive summary score of "15". On 05/01/2019 at approximately 10:30 a.m., Resident #59 was interviewed regarding life at the facility including meal times and the food served. Resident #59 stated, "I like to eat in my room...sometimes though I feel rushed." She was asked what that meant and she stated, "They come in here on the 3-11 shift and ask if you are done eating...if you aren't they stand over you and wait for you to finish...I usually just go ahead and give them my tray, I know they're rushing to get all the trays back to the kitchen, but damn." On 5/1/19 at 1:30 p.m. a group interview was conducted in the facility with seven (7) cognitive residents in attendance. During the interview, residents were asked if staff had ever "stood over them" waiting to retrieve the dinner tray. Three residents spoke up stating "Yes, they sure have. They come in and ask if you're finished eating...if you say no, then they stand there and you feel like you have to hurry up. It then makes you just go ahead and finish eating, even if you're not really done, just so they can get your tray; or, if you have food in your hand, they take the tray	F 550	Current residents were observed during the evening meal time to ensure dignity during the dining experience. Any issues were addressed immediately. Current staff educated on Residents right to a dignified existence and self-determination. Not to make Residents feel rushed at evening meal by not giving ample time to eat leisurely and not to stand by ready to pick up trays or continuously ask if done with meal. Audit of tray delivery to the rooms and tray pick up will be conducted at evening meal times for 6 weeks. Approx. 40 minutes should be given to Resident to eat their meals in room before asked if finished to pick up. Process will be reviewed in quarterly QA meeting.	

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F 550	Continued From page 7 and say they'll come back and get your glass, but they don't." The three residents all expressed this was common on the evening 3-11 shift. The above information was discussed with the administrator, DON (director of nursing) and the corporate nurse consultant during a meeting on 05/02/2019. No comments were made. No further information was obtained prior to the exit conference on 05/02/2019.	F 550		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584		6/4/19

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F 584	Continued From page 8 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and resident interview, the facility staff failed to ensure a clean, safe, comfortable, homelike environment in a resident room: Room 29. The bathroom in room 29 was observed unclean and malodorous. Findings include: On 5/1/19 beginning at 1:30 p.m. a group interview was conducted in the facility with seven cognitive residents in attendance. During the interview, two residents, who were roommates, stated: "There are four men in our room; the two of us don't need assistance to toilet, but the other two men have to be taken to the bathroom by the CNA (certified nursing assistant). The toilet seat almost always has [feces] on it. It's splattered all over the inside and the toilet isn't flushed. It usually always has urine in it from where the staff pour the urinal out but don't flush the toilet. Can't the CNA at least wipe off the seat and flush the toilet?" One resident stated "I have had to clean	F 584	F 584 Room #29 has been audited for cleanliness and smells and corrected and has been checked twice a day for compliance. Facility wide room rounds conducted to ensure cleanliness of bathrooms. Housekeeping and CNA□s have been educated to check for smells and cleanliness in each room they go into to provide care or meet Resident□s needs. Audit will be conducted daily for entire facility and rooms x2 times a day for 6 weeks checking for bathroom cleanliness and smells.	

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F 584	Continued From page 9	F 584		

the seat off before I can use the toilet; I don't feel I should have to do that."

On 5/1/19 at 3:40 p.m. room 29 was onserved and residents gave permission to enter bathroom. The toilet seat was an affixed seat that clamped onto the bottom of the toilet. There were small brown spatters which appeared to be feces; and the room smelled of urine. Two housekeeping staff, identified as OS (other staff) # 9 and # 10, stated the housekeeping staff usually cleaned resident bathrooms in the morning. OS # 10 stated she goes and checks her bathrooms prior to leaving for the day, but could not speak for anyone else. OS # 9 stated she was not sure why the CNAs who take the resident to the toilet, when there is a mess, don't clean it up. Both stated that during the hours housekeeping staff are in the building, if a resident bathroom needed attention, nursing staff would come and get them to come and clean the bathroom. Both staff stated that housekeeping services are provided during day shift; there are no housekeeping staff on evening/night shift.

On 5/2/19 at 10:45 a.m. the bathroom in room 29 was observed with fecal matter inside the toilet seat; there was also the same substance spattered on the top of the seat as well. The bathroom still smelled of urine. At 11:00 a.m., four CNAs who were identified as working on the hall where room 29 was located, were asked about the expectation if a resident was toileted, and made a "mess." CNA # 11 stated "Well, I am fairly new here, but I would clean it up." CNA # 9 and # 10 both agreed stating "You probably should speak with (name of CNA # 12) since she has that room the most." CNA # 12 was located and asked what she did if she took a resident to

Process will be reviewed in quarterly QA meeting.

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F 584	Continued From page 10 the bathroom and the bathroom needed cleaned afterwards. CNA # 12 stated "I clean it up." The administrator, DON (director of nursing), ADON (assistant director of nursing), and corporate consultant were informed of the above findings during a meeting with facility staff 5/2/19 beginning at 12:30 p.m. The administrator, when informed of the odiferous condition of the bathroom, stated "We are aware of the odor; it's alsomt as if the odor has 'seeped' into the tile...we are having the tile in that bathroom replaced to see if that will eliminate some of the odor." No further information was provided prior to the exit conference.	F 584		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observation, family interview, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to follow their abuse prevention policies regarding reporting and investigating an injury of unknown	F 607	F607 Resident #133 bruising has healed and skin being moisturized every day. Residents with current bruising will be	6/4/19

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F 607	Continued From page 11 origin for one of 38 residents in the survey sample. Resident #133 was observed with bruising of unknown origin on both of her thighs. The injuries of unknown origin were not immediately reported to the administrator or state agency, and were not thoroughly investigated as required by the facility's abuse prevention policies. The findings include: Resident #133 was admitted to the facility on 1/2/19 with diagnoses that included dementia, diabetes, neuropathy, gangrene of toe, peripheral vascular disease, heart disease, high blood pressure, osteomyelitis and arthritis. The minimum data set (MDS) dated 4/11/19 assessed Resident #133 with severely impaired cognitive skills and requiring extensive assistance of two people for transfers and bed mobility. Resident #133's family member was interviewed on 4/30/19 at 2:00 p.m. about quality of life and care for the resident in the facility. The resident's family member stated she was concerned about the resident's dry, flaking skin on the resident's feet and legs. Resident #133 was in bed with shorts on and the family member pointed to dry, flaking skin on the resident's feet. Resident #133 was observed at this time with a dark, purple circular bruise on the top of her left thigh, approximately 1.5 inches in diameter. The resident had a smaller, circular bruise, purple in color, on the top of her right thigh. Resident #133 stated she did not know how she got the bruises. The family member stated she had no idea how the resident was bruised. The family member stated she had seen the bruises during the last	F 607	reviewed to ensure origin has been identified. Staff has been educated on the entire Abuse /Neglect policies. Focusing specifically on reporting of any injury of any kind of unknown origin. Licensed staff educated on accurate skin assessments of entire body surface area. If injury detected to report immediately to Management, DON/Administrator. Skin assessments will be audited x 2 times a week for 6 weeks to ensure any new bruises have been investigated and/or reported. Process will be reviewed in quarterly QA meeting.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISONBURG HLTH & REHAB CNTR	1225 RESERVOIR STREET HARRISONBURG, VA 22801

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F 607	Continued From page 12	F 607		

couple of weeks when visiting. The family member stated the facility had not mentioned the bruises or possible cause of the injuries.

Resident #133's clinical record documented no assessment of the bilateral thigh bruises. Weekly skin assessments dated 4/17/19 and 4/24/19 documented "normal" skin color and condition with no new wounds.

On 5/1/19 at 10:07 a.m., accompanied by the licensed practical nurse (LPN #8) caring for Resident #133, a skin assessment was performed. LPN #8 observed the bruises on the resident's thighs at this time and stated she was not aware of the bruises until now. LPN #8 stated the second shift nurses were assigned weekly skin assessments for Resident #133. LPN #8 did not know how the resident was bruised.

On 5/1/19 at 11:00 a.m., the certified nurses' aide (CNA #7) routinely caring for Resident #133 was interviewed about the bruising. CNA #7 stated she noticed the bruises "a couple of weeks ago." CNA #7 stated she reported the bruises to one of the agency nurses working at the time but she did not remember the nurse's name. CNA #7 stated she did not know how the resident's thighs were bruised. CNA #7 stated the resident did not use a mechanical lift but transferred with assistance of two people.

On 5/1/19 at 4:26 p.m., unit manager (LPN #7) was interviewed about Resident #133's thigh bruises. LPN #7 stated she was not aware of the bruising and no assessment or incident form had been entered regarding the bruises.

On 5/2/19 at 8:35 a.m., the director of nursing

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(DON) and administrator were interviewed regarding Resident #133's bruising of unknown origin. The DON stated injuries of unknown origin were supposed to be assessed and reported to the administrator with notification to the family and physician. The DON stated an incident form should have been completed and entered at the time the bruises were found. The administrator stated injuries of unknown origin were to be reported and investigated per their company policy. The DON and administrator stated they were not aware of the bruises as no incident form or report had been sent to them concerning Resident #133's thigh bruises.

The facility's policy titled Injuries of Unknown Origin (effective 11/4/16) documented, "Injuries of unknown origin (injuries not witnessed or patient cannot state what happened) will be handled the same as an allegation of mistreatment, neglect, or abuse and must be reported to the Center Administrator...Any and all injuries of unknown origin to a patient are to be reported to a licensed nurse...A licensed nurse will assure patient safety...A licensed nurse will notify the Administrator and/or Director of Nursing immediately...A licensed nurse will closely monitor and document thoroughly the behavior and condition of the patient involved to evaluate any injury...For all patients involved in the incident with injury, a licensed nurse must notify the following...Attending Physician...Responsible Party...A licensed nurse is responsible for completing an Incident Record...The Director of Nursing is responsible for immediately notifying the Administrator of the injury of unknown origin. An initial report to the State Agency will be initiated...Investigative protocols will be immediately initiated..."

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F 607	Continued From page 14 The facility's policy titled Reporting Requirement/Investigations (effective 11/30/18) documented, "Immediately upon notification of any alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, the Administrator will immediately report to the State Agency, but not later than 2 hours after the allegation is made, if the event that caused the allegation involves abuse or results in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury...The Administrator and Director of Nursing will immediately initiate a thorough internal investigation of the alleged/suspected occurrence...The Administrator must thoroughly investigate and file a complete written report of the investigation...within five (5) working days of the incident..." These findings were reviewed with the administrator and director of nursing during a meeting on 5/1/19 at 4:30 p.m.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events	F 609		6/4/19

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F 609	Continued From page 15 that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to immediately report to the administrator and state agency an injury of unknown origin for one of 38 residents in the survey sample. Resident #133 was observed with bruising of unknown origin on both of her thighs. The injuries of unknown origin were not immediately reported to the administrator or state agency and were not thoroughly investigated. The findings include: Resident #133 was admitted to the facility on 1/2/19 with diagnoses that included dementia, diabetes, neuropathy, gangrene of toe, peripheral vascular disease, heart disease, high blood	F 609	F609 The Administrator has been notified of the bruising on resident #133. Current injuries of unknown origin are being reported to the Administrator and State agency. Education provided to all licensed and un licensed staff to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of Residents property, are reported immediately. Audit x 2 times a week for 6 weeks shift notes, reports, progress notes for	

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F 609	Continued From page 16 pressure, osteomyelitis and arthritis. The minimum data set (MDS) dated 4/11/19 assessed Resident #133 with severely impaired cognitive skills and requiring extensive assistance of two people for transfers and bed mobility. Resident #133's family member was interviewed on 4/30/19 at 2:00 p.m. about quality of life and care for the resident in the facility. The resident's family member stated she was concerned about the resident's dry, flaking skin on the resident's feet and legs. Resident #133 was in bed with shorts on and the family member pointed to dry, flaking skin on the resident's feet. Resident #133 was observed at this time with a dark, purple circular bruise on the top of her left thigh, approximately 1.5 inches in diameter. The resident had a smaller, circular bruise, purple in color, on the top of her right thigh. Resident #133 stated she did not know how she got the bruises. The family member stated she had no idea how the resident was bruised. The family member stated she had seen the bruises during the last couple of weeks when visiting. The family member stated the facility had not mentioned the bruises or possible cause of the injuries. Resident #133's clinical record documented no assessment of the bilateral thigh bruises. Weekly skin assessments dated 4/17/19 and 4/24/19 documented "normal" skin color and condition with no new wounds. On 5/1/19 at 10:07 a.m., accompanied by the licensed practical nurse (LPN #8) caring for Resident #133, a skin assessment was performed. LPN #8 observed the bruises on the resident's thighs at this time and stated she was not aware of the bruises until now. LPN #8 stated	F 609	accuracy and skin assessments to have clear description of Residents entire skin surface when skin assessments performed. Any issues identified will be addressed immediately. Process will be reviewed in quarterly QA meeting.	

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F 609	Continued From page 17	F 609		

the second shift nurses were assigned weekly skin assessments for Resident #133. LPN #8 did not know how the resident was bruised.

On 5/1/19 at 11:00 a.m., the certified nurses' aide (CNA #7) routinely caring for Resident #133 was interviewed about the bruising. CNA #7 stated she noticed the bruises "a couple of weeks ago." CNA #7 stated she reported the bruises to one of the agency nurses working at the time but she did not remember the nurse's name. CNA #7 stated she did not know how the resident's thighs were bruised. CNA #7 stated the resident did not use a mechanical lift but transferred with assistance of two people.

On 5/1/19 at 4:26 p.m., unit manager (LPN #7) was interviewed about Resident #133's thigh bruises. LPN #7 stated she was not aware of the bruising and no assessment or incident form had been entered regarding the bruises.

On 5/2/19 at 8:35 a.m., the director of nursing (DON) and administrator were interviewed regarding Resident #133's bruising of unknown origin. The DON stated injuries of unknown origin were supposed to be assessed and reported to the administrator with notification to the family and physician. The DON stated an incident form should have been completed and entered at the time the bruises were found. The administrator stated injuries of unknown origin were to be reported and investigated per their company policy. The DON and administrator stated they were not aware of the bruises as no incident form or report had been sent to them concerning Resident #133's thigh bruises.

The facility's policy titled Injuries of Unknown

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Origin (effective 11/4/16) documented, "Injuries of unknown origin (injuries not witnessed or patient cannot state what happened) will be handled the same as an allegation of mistreatment, neglect, or abuse and must be reported to the Center Administrator...Any and all injuries of unknown origin to a patient are to be reported to a licensed nurse...A licensed nurse will assure patient safety...A licensed nurse will notify the Administrator and/or Director of Nursing immediately...A licensed nurse will closely monitor and document thoroughly the behavior and condition of the patient involved to evaluate any injury...For all patients involved in the incident with injury, a licensed nurse must notify the following...Attending Physician...Responsible Party...A licensed nurse is responsible for completing an Incident Record...The Director of Nursing is responsible for immediately notifying the Administrator of the injury of unknown origin. An initial report to the State Agency will be initiated...Investigative protocols will be immediately initiated..."

The facility's policy titled Reporting Requirement/Investigations (effective 11/30/18) documented, "Immediately upon notification of any alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, the Administrator will immediately report to the State Agency, but not later than 2 hours after the allegation is made, if the event that caused the allegation involves abuse or results in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury...The Administrator and Director of Nursing will immediately initiate a thorough internal

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F 609	Continued From page 19 investigation of the alleged/suspected occurrence...The Administrator must thoroughly investigate and file a complete written report of the investigation...within five (5) working days of the incident..." These findings were reviewed with the administrator and director of nursing during a meeting on 5/1/19 at 4:30 p.m.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to ensure a thorough investigation of an injury of unknown origin for one of 38 residents in the survey sample.	F 610	F 610 Resident #133 bruising has healed and skin being moisturized every day. Evidence of all alleged violations that	6/4/19

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F 610	Continued From page 20 Resident #133 was observed with bruising of unknown origin on both of her thighs. The facility had no evidence these injuries of unknown origin were reported to the administrator or thoroughly investigated to determine any needed corrective actions. The findings include: Resident #133 was admitted to the facility on 1/2/19 with diagnoses that included dementia, diabetes, neuropathy, gangrene of toe, peripheral vascular disease, heart disease, high blood pressure, osteomyelitis and arthritis. The minimum data set (MDS) dated 4/11/19 assessed Resident #133 with severely impaired cognitive skills and requiring extensive assistance of two people for transfers and bed mobility. Resident #133's family member was interviewed on 4/30/19 at 2:00 p.m. about quality of life and care for the resident in the facility. The resident's family member stated she was concerned about the resident's dry, flaking skin on the resident's feet and legs. Resident #133 was in bed with shorts on and the family member pointed to dry, flaking skin on the resident's feet. Resident #133 was observed at this time with a dark, purple circular bruise on the top of her left thigh, approximately 1.5 inches in diameter. The resident had a smaller, circular bruise, purple in color, on the top of her right thigh. Resident #133 stated she did not know how she got the bruises. The family member stated she had no idea how the resident was bruised. The family member stated she had seen the bruises during the last couple of weeks when visiting. The family member stated the facility had not mentioned the	F 610	have been thoroughly investigated will be kept in file in DON□s office. Education provided to current staff regarding documentation of investigation and prevention of further potential abuse, neglect, exploitation while the investigation is in progress. Investigations in progress will be audited for 6 weeks. Assuring that investigation is documented and the protection of Resident involved is ongoing throughout investigation process. Process will be reviewed in quarterly QA meeting.	

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F 610	Continued From page 21	F 610		

bruises or possible cause of the injuries.

Resident #133's clinical record documented no assessment of the bilateral thigh bruises. Weekly skin assessments dated 4/17/19 and 4/24/19 documented "normal" skin color and condition with no new wounds.

On 5/1/19 at 10:07 a.m., accompanied by the licensed practical nurse (LPN #8) caring for Resident #133, a skin assessment was performed. LPN #8 observed the bruises on the resident's thighs at this time and stated she was not aware of the bruises until now. LPN #8 stated the second shift nurses were assigned weekly skin assessments for Resident #133. LPN #8 did not know how the resident was bruised.

On 5/1/19 at 11:00 a.m., the certified nurses' aide (CNA #7) routinely caring for Resident #133 was interviewed about the bruising. CNA #7 stated she noticed the bruises "a couple of weeks ago." CNA #7 stated she reported the bruises to one of the agency nurses working at the time but she did not remember the nurse's name. CNA #7 stated she did not know how the resident's thighs were bruised. CNA #7 stated the resident did not use a mechanical lift but transferred with assistance of two people.

On 5/1/19 at 4:26 p.m., unit manager (LPN #7) was interviewed about Resident #133's thigh bruises. LPN #7 stated she was not aware of the bruising and no assessment or incident form had been entered regarding the bruises.

On 5/2/19 at 8:35 a.m., the director of nursing (DON) and administrator were interviewed regarding Resident #133's bruising of unknown

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F 610	Continued From page 22	F 610		

origin. The DON stated injuries of unknown origin were supposed to be assessed and reported to the administrator with notification to the family and physician. The DON stated an incident form should have been completed and entered at the time the bruises were found. The administrator stated injuries of unknown origin were to be reported and investigated per their company policy. The DON and administrator stated they were not aware of the bruises as no incident form or report had been sent to them concerning Resident #133's thigh bruises.

The facility's policy titled Injuries of Unknown Origin (effective 11/4/16) documented, "Injuries of unknown origin (injuries not witnessed or patient cannot state what happened) will be handled the same as an allegation of mistreatment, neglect, or abuse and must be reported to the Center Administrator...Any and all injuries of unknown origin to a patient are to be reported to a licensed nurse...A licensed nurse will assure patient safety...A licensed nurse will notify the Administrator and/or Director of Nursing immediately...A licensed nurse will closely monitor and document thoroughly the behavior and condition of the patient involved to evaluate any injury...For all patients involved in the incident with injury, a licensed nurse must notify the following...Attending Physician...Responsible Party...A licensed nurse is responsible for completing an Incident Record...The Director of Nursing is responsible for immediately notifying the Administrator of the injury of unknown origin. An initial report to the State Agency will be initiated...Investigative protocols will be immediately initiated..."

The facility's policy titled Reporting

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F 610	Continued From page 23 Requirement/Investigations (effective 11/30/18) documented, "Immediately upon notification of any alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, the Administrator will immediately report to the State Agency, but not later than 2 hours after the allegation is made, if the event that caused the allegation involves abuse or results in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury...The Administrator and Director of Nursing will immediately initiate a thorough internal investigation of the alleged/suspected occurrence...The Administrator must thoroughly investigate and file a complete written report of the investigation...within five (5) working days of the incident..." These findings were reviewed with the administrator and director of nursing during a meeting on 5/1/19 at 4:30 p.m.	F 610		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information	F 655		6/4/19

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F 655	Continued From page 24 necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to develop a baseline care that included immediate care needs related to dialysis treatment for one of 38 residents in the survey sample. Resident #206 had no baseline care plan	F 655	F 655 Resident #206 has care plan regarding care for dialysis access catheter and services related to dialysis treatment. Current dialysis Residents care plans	

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F 655	Continued From page 25 regarding care for a dialysis access catheter and services related to dialysis treatment. The findings include: Resident #206 was admitted to the facility on 4/23/19 with diagnoses that included end stage renal disease, hepatic failure, diabetes, epilepsy, bipolar disorder and anxiety. The admission nursing assessment dated 4/23/19 assessed Resident #203 as alert and oriented to person, place and time. On 5/2/19 at 7:35 a.m., Resident #206 was observed on his bedside. The resident had a dressing on his right chest identified by the resident as his dialysis access site. Resident #206 stated he went to dialysis three times per week. Resident #206's clinical record documented a physician's order dated 4/23/19 for dialysis treatments each Tuesday, Thursday and Saturday due to end stage renal disease. There were no care orders regarding the resident's dialysis catheter/access site. Resident #206's baseline care plan (dated 4/23/19) included no problems, goals and/or interventions regarding dialysis treatments or care of the dialysis access site. On 5/2/19 at 10:00 a.m., the licensed practical nurse unit manager (LPN #7) was interviewed about an immediate care plan for dialysis care and any monitoring and/or care of the dialysis access catheter. LPN #7 reviewed the clinical record and stated she did not see any orders regarding care of the access site. LPN #7 stated	F 655	audited and reviewed for accuracy to meet all of Residents needs and to include focus regarding care for dialysis access catheter and services related to dialysis treatment. Current licensed staff educated on care plans being functional, accurate and to initiate care plans that covers dialysis and dialysis care needs. Audit care plans of current dialysis patients for accuracy and specific care needs twice weekly for 6 weeks. Process will be reviewed in quarterly QA meeting.	

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F 655	Continued From page 26 nurses were responsible for the baseline care plan upon admission. LPN #7 stated she did not see any items on the care plan regarding dialysis. This finding was reviewed with the administrator and director of nursing during a meeting on 5/2/19 at 12:20 p.m.	F 655		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657		6/4/19

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F 657	Continued From page 27 by: Based on observation, staff interview and clinical record review, the facility staff failed to review and revise a comprehensive care plan (CCP) for six of 38 residents in the survey sample, Residents #142, 69, 50, 92, 148, and 74. 1. Resident #142's care plan did not address her use and care for a central line. 2. Resident #69's care plan did not reflect a change in diet orders. 3. Resident #50's care plan was not reviewed and revised to address nutritional interventions. 4. Resident #92's care plan was not reviewed and revised to address nutritional interventions. 5. Resident #148's dietary and nutrition care plan was not revised. 6. Resident #74's care plan was not reviewed and revised to address a catheter being discontinued. The findings include: 1. Resident #142 was originally admitted to the facility on 05/04/16 and most recently readmitted on 03/21/19. Diagnoses include chronic obstructive pulmonary disease (COPD) anxiety disorder, gastroesophageal reflux disease (GERD), anemia, depression, diabetes II, difficulty walking, chronic kidney disease, nephritis, and hypertension. The most recent minimum data set (MDS) dated 04/17/19 assessed Resident #142 as cognitively intact for daily decision making with a score of 14.	F 657	F 657 Resident #142 has a care plan addressing use and care for a central line. Resident #69 care plan does reflect a change in diet order. Resident #50 Care plan was reviewed and revised to address nutritional interventions. Resident #92 care plan was reviewed, and nutritional interventions were updated. Resident #148 nutrition and dietary care plan was revised to meet current needs. Resident #74 care plan reviewed and revised to address catheter being discontinued. Residents with central lines have been care planned. Changes in diet orders to include nutritional interventions, dietary and nutrition care plans updated. Catheters whether started or discontinued are addressed in care plans. Shift reports will be audited 5 times weekly for order changes and to ensure that care plans are updated with any changes in care x6 weeks. New admissions care plans will be audited x 6 weeks for accuracy in meeting nutritional, central line needs and catheter needs. Process will be reviewed in quarterly QA meeting.	

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On 05/01/2019 at 7:35 a.m., Resident #142's clinical record was reviewed. The clinical record documented the following orders:

"Change dressing central line q7 days and PRN every evening shift every 7 day (s) for prevent infection. Order Date: 04/20/2019, Start Date: 04/20/2019."

"Change dressing on central line R chest q week every day every Thu (Thursday) for prevent infection. Order Date 4/10/2019, Start Date: 04/11/2019."

"Heparin Lock Flush Solution 10 UNIT/ML Use 5 cc intravenously every 12 hours for maintain central line patency. Order Date: 03/27/2019, Start Date: 03/27/2019."

"Sodium Chloride Solution 0.9%. Use 10 ml intravenously every 12 hours for flush central line R chest. Order Date: 03/27/2019, Start Date 03/27/2019."

A review of Resident #142's care plan did not include interventions for the use and care of the central line.

On 05/01/2019 at 1:30 p.m., the registered nurse (RN #3) who routinely provided care for Resident #142 was interviewed regarding if Resident #142 still had the central line. RN #3 stated the resident did still have the central line in her upper right chest area and was receiving regular scheduled flushes and dressing changes. RN #3 was asked who was responsible to update the care plans. RN #3 stated it can vary but normally it was the unit managers who updated the care plans.

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On 05/02/2019 at 8:05 a.m., the unit manager (LPN #2) was interviewed regarding Resident #142's central line and care plan updates. LPN #2 stated she was aware that Resident #142 still had the central line, however it was not being used at this time. LPN #2 stated the central line was being flushed and dressing changes were done. LPN #2 stated she had a conversation with Resident #142 a couple weeks ago about removing the line because it was currently not in use. Resident #142 declined to have it removed due based on her medical history of needing antibiotics and felt it was easier to leave the line in place. LPN #2 was asked who was responsible for updating the care plans to reflect interventions for the use and care of the central line, and she stated it was her responsibility.

These findings were discussed during a meeting on 05/02/19 at 12:15 p.m., with the administrator, director of nursing, assistant director of nursing, nurse consultant and unit managers.

2. Resident #69 was admitted to the facility on 02/06/18 with diagnoses that included difficulty walking, homelessness, diabetes II, gastroesophageal reflux disease (GERD), peripheral vascular disease (PVD), dehydration, protein-calorie malnutrition, pressure ulcer of the right heel, osteoarthritis, back pain, chronic obstructive pulmonary disease (COPD, and muscle weakness. The most recent minimum data set dated (MDS) dated 3/11/19, assessed Resident #69 as moderately impaired for daily decision making with a score of 9.

Resident #69's clinical record was reviewed on 05/01/19 and documented the diet order as:

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"Regular diet Level 4 - Pureed texture, Regular liquids consistency. Order Date: 04/05/2019, Start Date: 04/05/2019."

Resident #69's care plan created on 02/18/2019 documented the following focus area: "The resident has oral/dental health problems reported chewing/swallowing problems r/t edentulous and has not worn dentures in 2+ years, now on soft bit sized diet."

On 05/01/19 at 12:01 p.m., Resident #69 was observed eating lunch in his room. The meal ticket documented that the resident was receiving a pureed diet with regular consistency liquids and yogurt. Resident #69 had eaten all of the items on his tray with the exception of half of the yogurt and a magic cup. Resident #69 was asked about the food and his nutritional needs/likes. Resident #69 stated he had never been a big eater and he did not like the food because it looked like baby food and tasted like grits or dirt. Resident #69 was asked what he meant by the food tasted like grits or dirt. He stated it just wasn't like eating normal food at home and looked mushy. He stated "when I first came here, they were concerned with me having swallowing problems and getting choked; but that's over with now because they have changed my meals so often. I can pretty much eat anything I want if I take my time." Resident #69 stated he had lost his dentures and was not sure if he would even wear any now because it had been so long since he had been without them.

On 05/02/19 at 10:30 a.m., the dietary tech (OS #2) was interviewed regarding the Resident #69's diet order changes. OS #2 stated she had been involved with some of the changes and would

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need to review the resident's clinical record before she could reply. OS #2 stated she thought the speech therapist was responsible for updating the diet order care plans.

05/02/19 at 11:30 a.m., the therapy manager (OS #11) was interviewed regarding the multiple changes to Resident #69's diet orders. OS #11 stated Resident #69 was seen by the speech therapist for a few weeks when he was admitted with concerns of swallowing and chewing. OS #11 stated the resident did have multiple diet order changes in at attempt to upgrade his diet orders and preferences safely and the current order for Level 4- pureed was the correct diet order. OS #11 stated he had recently spoken with the unit manager (LPN #2) about another speech consult because Resident #69 had been complaining about the pureed food, despite eating a large percentage of his meals. OS #11 was asked who updated the care plans regarding diet order changes. OS #11 stated the speech therapist or anyone in the therapy department updated the care plans.

These findings were discussed during a meeting on 05/02/19 at 12:15 p.m., with the administrator, director of nursing, assistant director of nursing, nurse consultant and unit managers. During this meeting, LPN #2 stated she should have updated the care plans regarding the diet order changes.
3. Resident #50 was admitted to the facility on 12/22/16. Diagnoses for this resident included, but were not limited to: Alzheimer's dementia, colostomy, malaise, wandering, dementia with behavioral disturbances, and polyosteoarthritis.

The most current MDS (minimum data set) was a quarterly assessment dated 02/23/19. This MDS

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assessed the resident as a 9 cognitively, indicating the resident had moderate impairment in daily decision making skills. The resident was assessed as requiring supervision with at least one staff person assist for meal consumption.

The resident's annual MDS assessment dated 11/23/19 was reviewed for comparison and documented the same cognitive score. The resident was assessed as being independent with set up only for meal consumption.

Resident #50 was observed in the dining room on 04/30/19 at approximately 12:30 PM. The resident was sitting at a table with three other residents. Resident #50 was served a lunch tray that included mashed potatoes. The resident was observed eating the mashed potatoes with her fingers and not using eating utensils. No staff prompted or assisted the resident. A CNA (certified nursing assistant) was informed and the CNA stated, "...she does that."

On 05/01/19 the resident was observed in bed for breakfast and lunch.

On 05/02/19 at approximately 7:50 AM, the resident was observed alone in her room, eating a half sandwich on her bedside table. The resident was observed to take a bite and then took the sandwich apart and laid it on the bedside table; the resident had a carton of whole milk on the bedside table. The resident consumed only part of the sandwich.

At approximately 8:25 AM, the resident was observed again, alone in her room, sitting with the bedside table in front of her. The resident had a breakfast tray in front of her. The resident had

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bacon and scrambled eggs, with additional breakfast items. The resident also had a carton of fat free milk, in addition to the whole carton of milk (from the previous observation). The resident took a bite of bacon and put it down, then picked up her milk and sat it down and then attempted to eat scrambled eggs with her hands. The resident did not have assistance, prompting or oversight from staff during this time.

The resident's physician's orders were reviewed and documented, "...Regular diet Level 7-Regular texture, Regular liquids consistency...Med Plus 2.0 three times a day to promote weight stability 4 oz..."

The resident's CCP (comprehensive care plan) was reviewed and documented, "...ADL self-care deficit...Eating: The resident is able to feed self after set up [revision on: 05/08/18]...Resident has impaired cognitive function...thought process...cue, reorient and supervise as needed...Nutritional risk due to...dementia...behaviors...avoid significant weight change...administer medications...labs as ordered...monitor...appears concerned during meals...provide, serve diet as ordered. Monitor intake and record every meal. Provide supplement as ordered...weights as ordered..." All of these interventions were dated 12/22/16 with a revision and added weights as ordered on 01/04/17.

The resident's CCP did not specifically identify the resident's nutritional (supplements) interventions and did not document the resident's changing physical needs for nutritional consumption.

On 05/02/19 at approximately 10:30 AM, the

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dietary tech was interviewed regarding Resident #50 and interventions put in place to prevent weight loss. The dietary tech was asked for assistance in locating the most recent nutritional assessment for the resident.

The resident's weight change notes were reviewed and documented the following:

10/31/18 "...has a strong appetite and is consuming 51-100% consumed 100% of sandwich with RD as snack, had to remind her that she had a sandwich...confusion makes resident inappropriate to interview, weight stable..."

11/29/18 "...good appetite with 51-100%...dementia...potentially effect her weight...due to being distracted, forgetting to eat, or not being in room when food arrives...wanders...very active...she has lost some insignificant weight....would like her weight to stabilize..."

01/10/19 [LATE ENTRY] "...Value: 111.1...-10% change...Med Plus BID...wanders frequently...easily distracted from her meals...CNA's encourage her to continue eating and often has to redirect her to consume all of her meals...increase medplus to TID...add magic cups to lunch and dinner..."

02/07/19 "...Value 107.8..."

03/07/19 "...Value 105.0...has lost weight related to dementia...frequently active in the building...easily distracted from eating...needs constant cueing at meals to eat all of the food provided...will add magic cup BID to promote

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weight gain..."

05/01/19 "...medplus TID and magic cup BID...despite additional supplements pt continues with dementia...frequently distracted during meals...recommend house shakes with meals..."

The dietary tech presented a Nutrition assessment dated 12/26/16. This assessment documented that the resident's weight on 12/23/16 was 136.5 and documented the resident's caloric needs as 1600-1800 calories. The assessment documented that the patient was a nutritional risk due to dementia.

On 05/02/19 at approximately 1:00 PM, a meeting was held with the DON, administrator, corporate nurse, RD and dietary tech. The facility staff were made aware of Resident #50's significant weight loss and concerns that the resident had not been provided appropriate assistance, after it has been identified and documented that the resident needs much encouragement, prompting and supervision. The facility staff were also made aware of the lack of accurate accounting of supplements for this resident.

No further information and/or documentation was presented prior to the exit conference on 05/02/19 at 8:30 PM, to evidence that the resident's CCP was reviewed and revised to reflect the resident's current nutritional needs to maintain acceptable weight parameters.

4. Resident #92 was admitted to the facility on 02/20/08 originally and readmitted on 12/31/09. Diagnoses for Resident #92 included but were not limited to: high blood pressure, DM (diabetes mellitus), cellulits, CKD (chronic kidney disease),

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edema, chronic pain, osteoporosis, and anemia.

The most current MDS (minimum data set) was a quarterly assessment dated 03/24/19. This assessment documented the resident with a cognitive score of 15, indicating the resident was cognitively intact for daily decision making skills. The resident was independent for meal consumption.

The resident's weight records were reviewed and revealed the resident had a total weight loss was of 41.3 lbs in 6 months, or a 20.15% loss.

On 05/01/19 10:25 AM, Resident #92 was interviewed and stated that she has lost a lot of weight. Resident #92 stated that some food she doesn't like and some food she can't eat, because she doesn't like it.

The resident's current physician's orders were reviewed and documented, "Regular diet Level 7-Regular texture, regular liquids consistency."

The resident's current CCP was reviewed and documented, "...ADL self-care performance deficit...EATING: Provide tray setup. Encourage resident to feed self independently [created: 09/22/14] [Revision: 07/15/18]...is at nutritional risk...DM...edema...potential for significant weight loss changes...[created: 09//16/14] [revised: 05/01/19]...administer medications [03/05/15]...labs as ordered...provide, serve diet as ordered, monitor intake and record every meal...RD to evaluate and make diet change recommendations [09/16/14]...weights as ordered [created/revised: 03/05/15]..."

Nutritional notes were reviewed for this resident

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and documented the following:

11/08/18 "Weight change note...Value 189.4...she was happy with weight loss. Discussed importance of losing weight through healthy choices instead of unintentional weight loss...does not appear to have weight change or change of condition, medication or fluid changes present...question scale accuracy...will do weekly weights for next month..."

11/29/18 "...has lost 6.5 lbs this week. She has a strong appetite...not open to supplements...weight loss appears legitimate...appetite is good and she has ate as usual without changes...unit manager requested MD [medical doctor] to see for unusual weight loss with no clinical evidence to explain..."

Physician's progress note dated 11/30/18 documented, "...no appetite loss, nausea, vomiting, diarrhea, constipation, or abdominal pain...well developed and well nourished..." Weight loss is not mentioned in this progress note.

12/20/18 "...Value: 177.3...has lost weight over the past 3 months...believes weight loss is related to pneumonia she had in September, although most weight loss occurred post PNA [pneumonia]...appears slimmer in the face, shoulders and legs...is pleased with her weight loss...will not add supplement at this time as gradual weight loss is desirable...not interested in supplements..."

A physician's progress note dated 12/03/18 documented, "...no significant weight change...abdomen soft, nontender,

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nondistended...no palpable masses noted..." No other information was documented regarding weight loss or nutritional concerns.

Physician's progress note dated 12/27/18 documented, "...reports an approximate 25-30 pound weight loss since September...confirmed by her weight record...she reports sometimes she asks for things, as she can pick her own diet, and they are no longer available...appetite is lower...she feels that her appetite is decreased and her stomach has 'shrunk in size'...will talk to dietitian to see if she can stop by...favorite foods and get them to her..."

There was no documentation that the dietitian assessed the resident.

01/10/19 [LATE ENTRY] "...Value: 175.1...has had consistent weight loss since October 2018...weekly weights...weight has not stabilized...loss is beneficial...encourage...healthy, balanced meals..."

02/13/19 "...Value: 175.3...lost a significant amount of weight 10/1 -11/1 15.2 lb...weight loss was related to increased lasix...desirable ...related to pneumonia that caused poor intake [documentation reveals resident had pneumonia in Sept 2018]...declined nutrition supplements..."

The resident had lasix 60 mg ordered since July of 2018. The resident did receive additional doses during the month of September and October.

02/26/19 "...Value: 170.1...patient experienced out of facility weight loss, no acute loss or

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changes..."

There was no information in the resident's record to indicate that the resident was out of the facility during any time from October 2018 through May 2019.

03/07/19 "...weight change...decline in appetite...declines supplements..."

04/10/19 "...no nutritional intervention at this time due to pt refusal of supplements or large portions..."

04/30/19 "...resident willing to try various supplements...agreed to house shakes twice a week..."

On 05/02/19 at approximately 1:00 PM, a meeting was held with the DON, administrator, corporate nurse, RD and dietary tech. The facility staff were made aware of concerns for Resident #92's significant weight loss and concerns that the resident has not had a full nutritional assessment and/or other interventions implemented for this resident. The RD was asked if she was aware of this resident's significant weight loss. The RD stated that she was referred to this resident at the end of April and stated that she saw the resident today.

No further information and/or documentation was presented prior to the exit conference on 05/02/19 at 8:30 PM to evidence that this resident's CCP was reviewed and/or revised to reflect any of the above information for this resident.

5. Resident #148 was originally admitted on 10/10/2015 and readmitted on 02/04/2019 with

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diagnoses including, but not limited to: CVA (cerebrovascular accident), Hypertension, Anxiety, Vascular Dementia with Behaviors, Enterocolitis due to Clostridium Difficile (C. diff.), Unstageable Pressure Ulcer to Left Heel.

The most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 04/12/2019. Resident #148 was assessed as severely impaired in his cognitive status with a total cognitive score of six out of 15.

Resident #148's clinical record was reviewed on 05/01/19 at 3:30 p.m. During this review, his POS (physician order sheet) dated 05/01/2019, was noted to include, Dietary: Regular diet...Dietary Supplements: Med Plus 2.0 one time a day to promote weight stability and PO (oral) intake 4 oz (ounce)..."

Resident #148's weight record was reviewed and he was noted to have a significant weight loss over the past six months. His weights were: 11/01/18=183.1, 12/04/18=183.6, 01/01/19=181.4, 02/04/19=178, 03/04/19=168.8, 04/08/19=154.3, 05/02/19=154.9.

This resident's meal intake percentages was reviewed for the dates of 04/03/19 through 05/01/19. Out of 87 possible meals Resident #148 ate 50% or less of his meals 62% of the time. Out of 28 days this resident accepted a snack only eight days, or 29% of the time.

Resident #148's CCP (comprehensive care plan) included the following regarding nutrition. "Focus: (Name) Resident #148 is at nutrition risk r/t (related to) CVA, dementia with behaviors. Has

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hx (history) of wt (weight) refusal. (-) wt loss. pressure wound. (sic) Created on: 08/21/2015 Revision on: 04/16/2019. Goal: Will avoid significant weight change through next review. Created on: 08/21/2015 Revision on: 04/18/2019 Target Date: 07/15/2019 Interventions: Encourage healthy snacks and drinks between meals. Created on: 07/13/2017 Revision on: 02/08/2019. Provide diet as ordered. Monitor intake and record each meal. Offer substitute when intake less than 50%. Created on: 08/21/2015 Revision on: 02/08/2019. Weights and labs as ordered. Created on: 08/21/2015 Revision on: 02/08/2019."

On 05/02/2019 at 9:48 a.m. the Dietetic Tech was interviewed regarding Resident #148's weight loss and lack of interventions. She stated, "I added large portions on April 2nd in meal tracker, but forgot to document it in PCC (point click care). I added Prostat. I didn't add protein shakes or anything because it is such a large amount. We do have weight meetings. I take notes during the meetings and then record in PCC later."

The Administrative Team were informed of the above information during a meeting with the survey team on 05/02/19 at approximately 12:20 p.m. No further information was received prior to the exit conference on 05/02/19.

6. Resident #74 was admitted to the facility on 12/13/18. Diagnoses for Resident #74 included; Cellulitis, major depression, and stage two and stage four pressure ulcers with localized infection. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 3/11/19. Resident #74 was assessed with a score of 15 indicating cognitively

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intact.

On 5/2/19 review of Resident #74's medical chart evidenced that Resident #74 was admitted to the facility with a catheter in place to promote healing of sacral pressure wounds with infection. According to physician orders, Resident #74's catheter was discontinued on 1/24/19. Resident #74's care plan was also reviewed and indicated that Resident #74 was care planned to still have a catheter.

On 05/02/19 at 10:54 AM, registered nurse (RN #2, unit manager) was interviewed regarding the discontinuation order of the catheter and the care plan. RN #2 reviewed the care plan and the discontinuation catheter order for Resident #74 and verbalized that the care plan should have been revised to indicate Resident #74's catheter was discontinued.

On 05/02/19 at 11:02 AM, MDS coordinator (RN #4) was interviewed concerning updating Resident 74's care plan after a quarterly assessment was completed on 3/11/19 and indicated in section "H" that Resident #74 no longer had a catheter. RN #4 verbalized that it is the unit manager responsibility to update the care plan's as needed and quarterly and the MDS coordinator updates care plans for initial assessments, annual assessments and significant change assessments.

On 05/0219 at 12:47 PM, the above information was discussed with the administrator and director of nursing.

No other information was presented prior to exit conference on 5/2/19.

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F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, staff interview, facility document review and clinical record review, the facility staff failed to assess and initiate treatment for peeling, dry skin and foot wounds for one of 38 residents in the sample (Resident #133) and failed to follow physician orders for two of 38 residents in the survey sample (Resident #124 and #50). 1. Resident #133 was found with dry, peeling skin on her feet, a scabbed wound on her left heel and a black spot on her toe. The facility had not assessed or initiated treatment for the wounds and scaly skin. 2. Resident #124 was observed without physician ordered support hose in use. 3. Resident #50 was not provided a physician ordered orthopedic consultation in a timely manner. The findings include: 1. Resident #133 was admitted to the facility on 1/2/19 with diagnoses that included dementia,	F 684	F 684 Resident #133 dry skin and left heel assessed. Treatments updated and in place. Wound described as dark spot on her toe has healed. Resident #124 ted hose applied as ordered. Resident #50 has had an ortho. consult and future consult needs being addressed. Resident skin assessments audited for dry skin and wounds to ensure that these issues have been addressed. Residents with current orders for support hose were reviewed to ensure that hose are being applied and removed as ordered. Current residents with orthopedic consultation orders reviewed to ensure appointments set timely. New orthopedic orders will be reviewed x	6/4/19

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F 684	Continued From page 44 diabetes, neuropathy, gangrene of toe, peripheral vascular disease, heart disease, high blood pressure, osteomyelitis and arthritis. The minimum data set (MDS) dated 4/11/19 assessed Resident #133 with severely impaired cognitive skills and requiring the extensive assistance of one person for dressing and hygiene. Resident #133's family member was interviewed on 4/30/19 at 2:00 p.m. about quality of life and care for the resident in the facility. The resident's family member stated she was concerned about the dry, flaking skin on the resident's feet and legs. Resident #133 was in bed with shorts on and the family member pointed to dry, flaking skin on the resident's feet. The family member stated she had asked the facility about lotion or creams for her skin but none were routinely applied. The family member stated she had provided lotions but they were never applied, as the bottles were still full and unused. The family member stated the resident had a small wound on the left heel that had been previously treated by a wound clinic. The family member stated she did not know of any current treatments for the scabbed area and the resident was no longer seen by the wound clinic. On 5/1/19 at 10:07 a.m. accompanied by licensed practical nurse (LPN) #8, Resident #133's feet were observed. The bottom of both feet had dry, calloused skin that was peeling. The toenails of both feet were thick, yellow, long and jagged. There was a scabbed circular wound on the outer left heel with slight redness around the scab. The scabbed area was black/brown in color and slightly smaller than a dime. There was a small black spot on the tip of the second toe of the right foot. LPN #8 stated during this observation that	F 684	6 weeks to ensure appointments have been scheduled and arrangements made. Residents with support hose will be observed to ensure physicians orders are implemented accurately 5 times per week for 6 weeks. Weekly skin assessments will be reviewed x 6 weeks to ensure any areas of impairment have been assessed and treatments initiated as indicated. Licensed staff will be educated on accuracy of physician order implementation and that all findings during skin assessments will be reported and that all skin issues addressed timely. Process will be reviewed in quarterly QA meeting.	

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the resident had been discharged from the wound clinic "a couple of weeks ago" because the left heel wound was resolved. LPN #8 stated she was not aware of the scabbed area or the black spot on the toe and currently had no orders for treatment of the resident's feet.

Resident #133's clinical record documented the resident had a non-pressure, chronic diabetic ulcer on the left heel. The wound clinic report dated 4/10/19 documented the wound had been treated for 16 weeks and listed the left heel wound as, "Healed - Epithelialized" with treatments to the wound discontinued.

Resident #133's clinical record documented no assessment of the resident's left heel wound other than reports from the wound clinic. The clinical record documented no assessment of the left heel upon discharge from the wound clinic. There were no physician orders for treatment of the dry skin or the scabbed area. Weekly skin assessments dated 4/17/19 and 4/24/19 listed the resident's skin as normal in color and condition and made no mention of the peeling, scaly skin, the left heel scabbed area or the black spot observed on 4/30/19.

Resident #133's plan of care (revised 4/29/19) listed the resident had peripheral vascular disease. Interventions to prevent vascular complications included, "Educate the resident on the importance of proper foot care including: proper fitting shoes, wash and dry feet thoroughly, Keep toenails cut, inspect feet daily, daily change of hosiery and socks...Keep skin on extremities well hydrated with lotion in order to prevent dry skin and cracking of the skin...Monitor the extremities for s/sx [signs/symptoms] of

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injury, infection or ulcers..." The care plan also listed the resident was at risk for skin impairment due to confusion, decreased mobility, incontinence, pain and diabetes. Interventions to prevent skin impairment included, "Keep skin clean and dry...Lotion to dry skin...Moisture barrier creams as needed for protection of skin...Weekly skin assessments."

On 5/1/19 at 2:00 p.m., LPN #8 was interviewed again about Resident #133's left heel and scaly skin. LPN #8 stated she requested the nurse practitioner to evaluate the left heel scabbed area and the black spot on the resident's right second toe. When asked when these areas first appeared, LPN #8 stated she did not know, as second shift was responsible for skin assessments on Resident #133. LPN #8 stated she did not know if the scab was on the resident's left heel wound when she was discharged from the wound clinic on 4/10/19.

On 5/2/19 at 7:37 a.m., the unit manager (LPN #7) was interviewed about Resident #133's left heel scabbed area, black spot on toe and dry, peeling skin on her feet. LPN #7 stated she talked with the nurse responsible for Resident #133's skin assessments. LPN #7 stated the nurse reported the scab on the left heel "had been there." LPN #7 stated the nurse reported the scab was present when the resident was discharged from the wound clinic but she did not document it on the skin assessments. LPN #7 stated the nurse thought the dry skin and left heel wound were "not new" so she did not list them on the assessment form. LPN #7 stated the nurse did not understand the assessment form currently in use for documenting wounds and skin conditions.

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On 5/2/19 at 8:42 a.m., the director of nursing (DON) was interviewed about skin assessments and records of skin conditions and/or wounds. The DON stated skin assessments were supposed to be completed upon admission and weekly by the assigned nurse. The DON stated the skin assessment form had a place to note any new wounds and an assessment should include the size, location and description of the wound and/or condition. The DON stated nurses were expected to report and seek treatment for any condition or wounds found during assessments.

These findings were reviewed with the administrator and director of nursing during a meeting on 5/2/19 at 12:20 p.m.

2. Resident #124 was admitted to the facility on 3/22/19. Diagnoses for Resident #124 included; Fracture of left femur, atrial fibrillation, and interstitial pulmonary disease. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 4/24/19. Resident #124 was assessed with a score of 12 indicating moderately cognitively intact.

On 5/1/19 Resident #124's clinical record was reviewed. An active physician's order dated 4/8/19 read "Wear your TED hose during the day and off at night [...]"

On 5/1/19 at 11:20 AM, Resident #124 was observed in therapy without TED hose in place.

05/01/19 at 11:40 AM, the certified nursing assistant (CNA #1, assigned to Resident #124) was interviewed concerning the finding. CNA #1 verbalized that she was unaware that Resident

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#124 needed TED hose and also went on to say she (CNA #1) had gotten Resident #124 up for breakfast and assisted Resident #124 with dressing.

This surveyor and CNA #1 then went to Resident #124's room to look for TED hose, but were unable to find any TED hose.

LPN #1 was then interviewed with CNA #1 present. LPN #1 verbalized that she had not been in Resident #124's room to put TED hose in place and also verbalized that sometimes Resident #124 refuses the TED hose. It was explained to LPN #1 that according to CNA #1, Resident #124 had been out of bed since breakfast.

Resident #124's treatment administration record was reviewed for the month of April and May 2019. The treatment records did not evidence that Resident #124 had been refusing TED hose. Also nursing progress notes were reviewed for the month of April and did not evidence that Resident #124 had refused TED hose.

05/01/19 04:19 PM the above information was presented during an end of day meeting with the Administrator and director of meeting.

No other information was presented prior to exit conference on 5/2/19.

3. Resident #50 was admitted to the facility on 12/22/16. Diagnoses for this resident included, but were not limited to: Alzheimer's dementia, colostomy, malaise, wandering, dementia with behavioral disturbances, and polyosteoarthritis.

The most current MDS (minimum data set) was a quarterly assessment dated 02/23/19. This MDS

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assessed the resident as a 9 cognitively, indicating the resident had moderate impairment in daily decision making skills. The resident was additionally assessed as requiring extensive assistance for dressing, toileting, and hygiene. The resident was assessed as requiring supervision with at least one staff person assist for meal consumption. The resident was assessed as having pain occasionally, with a numeric score of 4 (scale 1-10), no verbal descriptors indicated. No other pain assessment information was documented.

The resident's annual MDS assessment dated 11/23/19 was reviewed for comparison and documented the same cognitive score. The resident was assessed as requiring limited assistance with at least one person for bed mobility, transfers, and toileting. The resident was assessed as being independent with set up only for meal consumption. This MDS documented the resident had no pain.

During clinical record review, it was documented in a nursing note dated 01/06/19 [3:52 PM] that the resident had a "possible" fall on 01/05/19 with bruising and swelling to the left arm and left hip. According to the documentation x-rays were ordered and upon further assessment the resident had worsening deformation and dislocation of left wrist and left elbow. An order was obtained to send the resident out to the ED [emergency department] for evaluation.

A change of condition note dated 01/06/19 [3:58 PM] documented that the resident had uncontrolled "fall" pain.

A nursing note dated 01/06/19 [10:36 PM]

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documented that the resident returned back to the facility at 7:30 PM with negative findings and negative X-rays. The nursing note documented that the resident continues with swelling and bruising with deformity of left forearm/wrist and that a house physician was currently in the facility who assessed the resident and ordered stat X-rays of the left wrist for pain and deformity; X-ray completed.

A radiology report for examination date 01/06/19 [9:27 PM] was reviewed and documented, "...Reported date: 01/07/19 1:30 AM...ulna rod is noted with its distal tip extending beyond the ulnar. Distal aspect of ulna and radius is surgically absent cortex...no acute fracture. 2nd rod is noted in soft tissues lateral to ulna. Wrist is deformed...caudal migration of carpal bones...soft tissue swelling....osteopenia...no acute fracture...Recommend orthopedic consult, 2nd rod is noted in soft tissues lateral to ulna. Markedly limited evaluation since 2 images of lateral view only was provided..."

A nursing note dated 01/07/19 [12:31 AM] documented, "...has a history of dementia and wandering...has been wandering the facility...guarding her left arm, complaining of pain..."

Nursing notes documented the following events:

01/07/19 [8:43 AM] "....unwitnessed fall on 01/05/19....observed resident sitting on floor...got self up off floor...pain continued to be uncontrolled...sent out to ED...had X-rays completed all negative...[name of physician] in facility...assessed injuries...ordered stat X-ray...uncontrolled pain...no acute fx...There is a

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recommendation that resident have an ortho consult..."

Nursing notes on 01/07/17, 01/08/19, 01/09/19 documented that the resident continued with pain, swelling, bruising and discoloration to the left arm/wrist.

A physician's order dated 01/07/19 documented for the resident to have an orthopedic consult related to possible dislocation of the resident's left arm/wrist.

On 01/09/19 a nursing note documented that the resident yelling out in pain and crying noted when attempting to change resident's shirt and that the patient was unable to verbalize location of pain; NP [nurse practitioner] in to evaluate resident and order obtained for PRN [as needed] pain medication.

A physician's order for Tramadol 25 mg [milligrams] was ordered on 01/09/19 for moderate to severe pain.

A nursing note dated 01/15/19 documented that "...Resident continues with discoloration and rod displacement to LUE [left upper extremity] s/p [status post] recent fall..."

A nursing note dated 01/17/19 documented, "...alert with confusion...pain meds administered x 2...health labs delivered a CD of images of pts wrist...medical records notified..."

A nursing note dated 05/01/19 documented, "...holding left arm and facial grimacing...hurt and tired...refused to get OOB (out of bed)..."

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Resident #50's clinical records were reviewed and did not reveal that the physician's ordered orthopedic consult was completed.

The resident's MAR's (medication administration records) were reviewed for January, February, March, April, and May of 2019. The MARs revealed the following:

January 2019: The resident received Tramadol 25 mg a total of 38 times from 01/09/19 [order date] through the end of the month 01/31/19. The resident received Tylenol 650 mg a total of 10 times from 01/09/19 through 01/31/19.

February 2019: The resident received Tramadol 25 mg a total of 36 times for the whole month of February. The resident received Tylenol 650 mg a total of 3 times for the entire month of February.

March 2019: The resident received Tramadol 25 mg a total of 50 times during this month and received Tylenol 650 mg a total of 9 times for the month.

April: The resident received Tramadol 25 mg a total of 46 times and Tylenol 650 mg a total of 2 times for the entire month.

May 2019: The resident received Tramadol 25 mg a total of 4 times from May 1st and May 2nd. The resident did not receive any Tylenol 650 mg on those days.

The resident's current CCP (comprehensive care plan) was reviewed and documented, "...Resident had an actual fall...will resume usual activities without further incident...cardiovascular referral [sic]...monitor changes in behavior...vital signs as

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needed...Pain [created on 12/22/16] related to osteoarthritis...history of compression fracture...will have no decreased complaints of pain...encourage relaxation techniques and provide diversional activities...repositioning, relaxation...heat/cold...to relieve pain prior to medicating per...order...[created on: 12/22/16 revised on: 04/27/17]...medicate as ordered [created on: 12/22/16]...notify MD for pain not relieved with medication or new complaints of pain...pre-medicate for painful procedures [created on 12/22/16]..."

A physician's progress note [written by an NP] dated 01/03/19 documented, "...continue to use acetaminophen for osteoarthritic pain..."

A physician's progress noted dated 01/09/19 [written by an NP] documented, "...increased pain and decreased activity since a fall on Sunday that was unwitnessed...Tramadol 25 mg..."

A physician's progress note dated 03/04/19 [written by a PA-C] documented, "...seen, only 1/9 since her last...exam secondary to a unwitnessed fall and decreased activity for several days...emergency room...concern for dislocation of a rod in her right arm. She was to have follow up with orthopedics. I would like to check this...memory, judgement, insight severely impaired...Nursing reports Tramadol PRN given at the beginning of the day has been helpful..."

A physician's progress note dated 04/11/19 [written by a PA-C] documented, "...had a fall within the last several months, decreased activity, ...concern for dislocation of rod in her right arm...I do believe she did go to orthopedic follow up for this...we will continue to follow closely..."

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A physician's progress note dated 04/30/19 [written by a PA-C] documented, "...severe dementia...Continue to implement Tramadol for agitation to assess if pain is part of the picture...We will continue to follow up with scheduling as well as nursing unit manager about status of her orthopedic consultation for the possibility of a dislocated rod in her right arm..."

On 05/01/19 at 4:15 PM, the survey team met with the DON (director of nursing), administrator and corporate nurse consultant were made aware of concerns regarding the above information and was asked for assistance in locating the completed physician orthopedic consult.

On 05/02/19 at 9:00 AM, an interview with LPN #3, who was the UM (Unit Manger) for Resident #50 was conducted. LPN #3 was made aware that there was no evidence of an orthopedic consult that the physician had ordered and that this had also been recommended by the physician who read the original X-ray report. LPN #3 was made aware that the resident has been receiving Tramadol almost daily and multiple times on some days for pain related to her wrist/arm from a fall that occurred in January 2019. The LPN stated that she would look to see if it was done.

LPN #3 later returned and stated that the orthopedic consult had not been completed and was not sure why.

An interview was conducted with medical records, OS #1 (other staff #1) on 05/02/19 at 9:25 AM. OS#1 stated that the an appointment, along with transportation confirmation was made for this

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F 684	Continued From page 55 resident for 03/14/19. OS#1 stated that the transportation company did not show up to pick the resident up. OS#1 stated that another appt was made for the resident on 04/22/19 and that appt was canceled; the resident's appt is now set up for May 8th, 2019. OS #1 stated that she didn't know the resident was in pain or needed to be seen right away or she would have attempted to make alternate arrangements. The survey team met with the administrator, DON and corporate nurse consultant on 05/02/19 regarding Resident #50 not being seen by ortho for a possible dislocated rod in her arm and that staff were continually treating this resident with opioid pain medication for months. The facility staff were made aware that this physician's order was written on January 7th, 2019 and it was now 4 months later and the resident still has not been seen and has been being treated with opioid medications practically on a daily basis. No further information and/or documentation was presented prior to the exit conference on 05/02/19 at 8:30 PM to evidence that this delay in treatment was unavoidable, the facility failed to provide treatment and services as ordered by the physician in a timely manner for Resident #50.	F 684		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's	F 687		6/4/19

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F 687	Continued From page 56 medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review the facility staff failed to provide foot care for two of 38 residents in the survey sample, Resident #69 and Resident #133. 1. Resident #69 was observed with long, pointed mycotic nails, calluses and dry skin on both of his feet 2. Resident #133, with history of diabetes and peripheral vascular disease, was observed with thick, long, jagged toenails and dry, scaling, calloused skin on both feet. The findings include: 1. Resident #69 was admitted to the facility on 02/06/18 with diagnoses that included difficulty walking, homelessness, diabetes II, gastroesophageal reflux disease (GERD), peripheral vascular disease (PVD), dehydration, protein-calorie malnutrition, pressure ulcer of the right heel, osteoarthritis, back pain, chronic obstructive pulmonary disease (COPD), and muscle weakness. The most recent minimum data set dated (MDS) dated 3/11/19, assessed Resident #69 as moderately impaired for daily decision making with a score of 9. Under section G functional status, at G0110, (J) Personal Hygiene, Resident #69 was assessed as requiring extensive assistance with one person physical assistance.	F 687	F 687 Resident #69 was provided care for toe nails, feet and legs being moisturized daily. Resident #133 podiatry care is being provided and legs and feet being moisturized daily. Foot audit conducted to evaluate current status of nails and skin. Any issues identified were addressed at the time of the audit. Education provided to current nursing staff about checking feet daily and reporting any care needs to licensed nurse and to physician if needed. Foot care audit will be conducted facility wide weekly x 6 weeks. Care will be provided in facility or appointment made and transportation provided for outside podiatry service. Process will be reviewed in quarterly QA meeting.	

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On 04/30/19 at 2:30 p.m., Resident #69 was interviewed regarding his stay at the facility. Resident #69 was asked about his ability to carry out his activities of daily living (ADLs). Resident #69 stated "they (staff) don't want me to fall and often remind me to call for help. They help me get me up, give me baths and get me dressed." Resident #69 was asked if he had pressure ulcers. Resident #69 wiggled his toes and stated "yes on my heels & toes, I have to keep my heels up when I'm in the bed and the nurse comes in and changes my bandages every other day." He stated his toes and feet hurt him sometimes and he was not able to cut his own toenails.

On 05/01/19 at 4:06 p.m., with Resident #69's permission a wound care dressing change was observed. The licensed practical nurse (LPN #5) completed the wound care dressing change to the left great toe and skin prep was applied to both of his heels. Resident #69 was observed with long, pointed mycotic nails, calluses and thick dry skin on both of his feet. Resident #69 was asked if he had ever seen the podiatrist and he stated no. He was asked if he would be interested in being seen by the podiatrist and he stated yes. LPN #5 was interviewed regarding how the podiatrist referrals were made and scheduled. LPN #5 stated the facility had a podiatrist who came to the facility to see the residents. LPN #5 stated the certified nursing assistants (CNA) would notify the charge nurse of the need/request for a podiatrist appointment and the nurse would notify the MDS coordinator who would schedule the appointments for the in-house podiatry provider. LPN #5 stated the unit managers had a podiatry list as well for the in-house podiatry provider. LPN #5 stated she

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did not know why Resident #69 had not been referred to the podiatrist given the condition of his feet.

On 05/01/19, Resident #69's clinical record was reviewed. The comprehensive care plan which was created on 02/07/2019 documented Resident #69 had an ADL self-care performance deficit related to limited mobility and the pressure ulcers to the right heel, left foot and left great toe, which included weekly skin assessments and heel placement while in bed as interventions. The clinical record documented no explanation why the resident had not been referred for podiatry care nor the resident refusing such care.

These findings were discussed during a meeting on 05/01/19 at 4:30 p.m., with the administrator, director of nursing, assistant director of nursing, nurse consultant and unit managers. The administrator stated the facility no longer had an in-house podiatrist and they have to send the residents out for podiatry.

2. Resident #133 was admitted to the facility on 1/2/19 with diagnoses that included dementia, diabetes, neuropathy, gangrene of toe, peripheral vascular disease, heart disease, high blood pressure, osteomyelitis and arthritis. The minimum data set (MDS) dated 4/11/19 assessed Resident #133 with severely impaired cognitive skills and requiring the extensive assistance of one person for personal hygiene.

On 5/1/19 at 10:07 a.m. accompanied by licensed practical nurse (LPN) #8, Resident #133's feet were observed. The bottom of both feet had dry, calloused skin that was peeling. The toenails of both feet were thick, yellow, long and jagged. There was an accumulation of a brown substance

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F 687	Continued From page 59 under the toenails. Resident #133's clinical record documented no record of podiatry care since her admission on 1/2/19. Resident #133's plan of care (revised 4/29/19) listed the resident had peripheral vascular disease. Interventions to prevent vascular complications included, "...Keep toenails cut, inspect feet daily...Keep skin on extremities well hydrated with lotion in order to prevent dry skin and cracking of the skin...Monitor the extremities for s/sx [signs/symptoms] of injury, infection or ulcers..." On 5/1/19 at 10:07 a.m., LPN #8 was interviewed about the resident's long, jagged toenails and peeling skin. LPN #8 stated the resident was diabetic and required podiatry to cut/trim her toenails. LPN #8 stated the facility no longer had a podiatrist that came to the facility. LPN #8 stated residents needing podiatry care now had to be sent out of the facility for treatment. LPN #8 stated there were no current orders for treatment of the dry skin on the resident's feet. This finding was reviewed with the administrator and director of nursing during a meeting on 5/1/19 at 4:30 p.m.	F 687		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		6/4/19

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F 689	Continued From page 60 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, staff interview and clinical record review, the facility staff failed to ensure a safe room environment for one of 38 residents in the survey sample and failed to ensure safety devices were in place for one of 38 residents in the survey sample. 1. Resident #33 was observed aggressively pulling on the electrical cord and cable cord hanging unsecured from a wall-mounted television. 2. Resident #62 did not have fall mats and an alarm in place as required in the plan of care for safety. The findings include: 1. Resident #33 was admitted to the facility on 5/11/17 with a re-admission on 10/6/18. Diagnoses for Resident #33 included dementia with behaviors, high blood pressure, cerebral atherosclerosis, obesity, epilepsy, asthma, atrial fibrillation and diabetes. The minimum data set (MDS) dated 2/11/19 assessed Resident #33 with moderately impaired cognitive skills and with physical behaviors directed toward others (hitting, kicking, pushing, scratching, grabbing). On 5/1/19 at 9:37 a.m., Resident #33 was observed seated in her wheelchair in her room accompanied by a family member. The resident was aggressively pulling on the electrical cord and cable cord hanging from a wall mounted	F 689	F 689 Resident #33 the TV electrical cord and cable cord have been secured and out of reach. Resident #62 fall mats and alarm are in place. TV cords and cables in resident rooms have been evaluated to ensure that they are secured for safety. Residents with fall mats and alarms were reviewed to ensure that they are in place per the residents plan of care. Education will be provided to current staff on reporting of any unsecured TV cords or cables to the Maintenance department for correction. Education will be provided to current nursing staff about utilization of fall mats and pressure alarms per the plan of care. 10 Residents will be audited 2x/week for 6 weeks for utilization of fall mats and pressure alarms to validate that Care Plan and device assessment match what is in residents room. TV cords and cables will be observed during the audit to ensure that they are secure and safe. Process will be reviewed in quarterly QA meeting.	

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television. The television was attached to a wall bracket approximately 6 feet from the floor. The electrical cord from the television was hanging unsecured below the television. This cord was plugged into a wall outlet below the television, creating a loop in the cord. A cable cord was also hanging from the television to a hole in the wall located about a foot above the floor. The resident was continually and aggressively pulling/yanking on both of the hanging cords with the family member attempting to stop the resident saying "No, No." The family member was interviewed at this time about the resident pulling on the cords. The family member stated the resident had behaviors that included grabbing and pinching. The family member stated the resident pulled frequently on the electrical/cable cords hanging from the television. The family member stated if she moved the resident to the center of the room, the resident tried to pinch or scratch the roommate. When asked if anyone had attempted to cover or secure the electrical and cable cords, the family member stated she did not know.

On 5/1/19 at 9:40 a.m., the licensed practical nurse (LPN #6) caring for Resident #33 was interviewed about the resident pulling on the television cords. LPN #6 stated the resident frequently pulled and grabbed at items and others. LPN #6 stated, "She [Resident #33] will try to pinch the roommate. That's why we try to keep them apart." Concerning the hanging electrical and cable cords, LPN #6 stated, "That's a safety issue."

On 5/1/19 at 9:44 a.m., Resident #33 was observed in her room still aggressively pulling on the television electric cord/cable. The family member was tearful, telling the resident to stop

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and continually attempting to remove the cords from the resident's hands.

On 5/1/19 at 9:48 a.m., the unit manager (LPN #7) was informed of the observations and interviewed about the unsecured electric cord/cable accessible to Resident #33. LPN #7 stated she was not aware of the electrical cord/cable hanging in Resident #33's room.

Resident #33's plan of care (revised 12/21/18) listed the resident was physically aggressive due to poor impulse control. Behaviors listed included yelling out, hitting staff, refusing care and grabbing. Interventions to minimize behaviors included medications, assess and anticipate needs and choices about activities. The care plan documented, "When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later."

This finding was reviewed with the administrator and director of nursing during a meeting on 5/1/19 at 4:30 p.m.

2. Resident #62 was admitted to the facility on 3/29/18 with most recent readmission on 2/28/19. Diagnoses for Resident #62 included; Peripheral vascular disease, dementia, unsteadiness on feet, muscle weakness, and hemiplegia affecting left side. The most current MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 3/4/19. Resident #62 was assessed with a score of 13 indicating cognitively intact.

On 5/1/19 Resident #62's care plan was reviewed and documented a focus area of falls with injury

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F 689	Continued From page 63 related to confusion and history of falls. Interventions for falls and safety awareness included "[...] Fall mats, pressure alarm [...]" This intervention was put in place on 8/11/18 and was updated on 3/1/19. According to nursing progress notes the last time Resident #62 fell was on 4/30/19, the progress note read: "Resident was observed on floor in front of bed. Small skin tear to wrist [...]" On 5/1/19 at 9:30 AM, Resident #62 was observed in bed without fall mats or pressure alarm in place. On 05/01/19 at 10:28 AM, Resident #62 was observed with certified nursing assistant (CNA #2), and did not have fall mats in place or pressure alarm in place while in bed. CNA #2 verbalized that nurses will usually tell CNAs what Resident's needs are. Resident #62's Kardex was observed with CNA #2, which read "Assistive Devices: fall mats, pressure alarm." On 05/01/19 at 4:19 PM, during an end of day meeting, the administrator and director of nursing were made aware of the above finding. No other information was presented prior to exit conference on 5/2/19.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and	F 692		6/4/19

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F 692	Continued From page 64 percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, facility staff failed to maintain acceptable parameters of nutriutional status for three out of 38 resident's; Residents #148, #92, and #50. 1. Resident #148 was noted with less than 50% consumption of more than half his meals. He was observed to not eat breakfast with staff not providing any cueing or assistance from staff and was not offered a substitute as documented as an intervention on his care plan. Resident #148 experienced a 14.6% significant weight loss from 01/01/19 through 05/02/19. 2. Resident #50 experienced a significant weight loss with no nutrition interventions added. The resident lost 7.03% [8.4 lbs] in 3 months, lost	F 692	F 692 Resident #148 has been evaluated by RD/Dietary Tech and care plan has been updated to include substitutes when tray not desired and care plan has been updated. Resident #50 has been evaluated by RD/Dietary Tech all nutritional interventions recommended are implemented and care plan updated. Resident #92 has been evaluated by RD/Dietary Tech all nutritional interventions recommended are implemented and care plan updated. Current residents with documented significant weight loss were reviewed to ensure that nutrition and hydration status are being addressed.	

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F 692	Continued From page 65 12.13.% [14.5 lbs] in 5 months and lost 13.39% [16.0 lbs] as of May 2, 2019. 3. The facility staff failed to implement nutrition interventions to prevent a significant weight loss for Resident #92. Findings included: 1. Resident #148 was originally admitted on 10/10/2015 and readmitted on 02/04/2019 with diagnoses including, but not limited to: CVA (cerebrovascular accident), Hypertension, Anxiety, Vascular Dementia with Behaviors, Enterocolitis due to Clostridium Difficile (C. diff.), Unstageable Pressure Ulcer to Left Heel. The most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 04/12/2019. Resident #148 was assessed as severely impaired in his cognitive status with a total cognitive score of six out of 15. He was coded on this MDS as being independent with set-up only for eating. Included under "Section K - K0300. Weight Loss, Loss of 5% or more in the last month or loss of 10% or more in last 6 months: 2. Yes, not on prescribed weight-loss regimen..." Resident #148 was also coded on this MDS as having an unstageable pressure ulcer. A significant change MDS dated 02/08/19 was reviewed for comparison. Resident #148 was coded on this MDS as being independent with set-up only for eating. He was also coded as as at risk for having a pressure ulcer but not having any at the time of the assessment. The next most recent MDS was a quarterly	F 692	Education to current licensed staff in proper documentation and reporting to dietary staff and or physician of any changes in eating habits that includes decrease intake or changes in health status affecting food intake. Residents identified with nutrition and hydration issues will be reviewed in the weight meetings and interventions implemented as indicated. Audit will be conducted weekly for 6 weeks to insure weights are accurate and any identified weight loss is addressed with interventions implemented. Process will be reviewed in quarterly QA meeting.	

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assessment with an ARD of 01/27/19. On this MDS, Resident #148 was coded as requiring limited assistance with one person physical assistance for eating.

On 05/01/19 at 8:13 a.m., Resident #148 was observed in bed, with the head of bed elevated, eyes closed, and his breakfast tray set up directly over his lap on the bedside table. Resident #148 was interviewed and stated, "I am tired. I am going to eat." The breakfast tray had not been touched by the resident.

The unit manager, RN #2 (registered nurse) was interviewed at 8:20 a.m. regarding Resident #148's eating status. RN#2 stated, "I am fairly certain, up until this point, he has been feeding himself. I will check with his aide to be sure."

CNA #6 (certified nursing assistant) was interviewed at 8:34 a.m. regarding Resident #148's meal intake. CNA #6 stated, "I set him up and came back in here and woke him up to eat. He normally doesn't eat much breakfast. He only drank a little coffee this morning. He usually does much better at lunch. It depends on how tired he is. We set him up and then check on him a couple of times. If he doesn't eat, then we will try to assist him."

Resident #148 was observed on 05/01/19 at 1:14 p.m., sitting up in his wheelchair in his room, eating lunch. His tray was set up and he was feeding himself. He had eaten approximately 25% at the time of the observation. He had eaten all his peas, mashed potatoes and bread. He had not eaten his meat or cooked apples. It was recorded on his meal intake sheet that he consumed 51-75% of his lunch tray.

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Resident #148's clinical record was reviewed on 05/01/19 at 3:30 p.m. During this review, his POS (physician order sheet) dated 05/01/2019, was noted to include, Dietary: Regular diet...Dietary Supplements: Med Plus 2.0 one time a day to promote weight stability and PO (oral) intake 4 oz (ounce)..." was added 03/07/2019.

Resident #148's weight record was reviewed and he was noted to have a significant weight loss over the past six months. His weights were:
01/01/19=181.4
02/04/19=178
03/04/19=168.8
04/08/19=154.3
05/02/19=154.9

This resident's meal intake percentages was reviewed for the dates of 04/03/19 through 05/01/19. Out of 87 possible meals Resident #148 ate 50% or less for over half of his meals. Out of 28 days this resident accepted a snack only eight days.

The most recent "Comprehensive Nutrition Assessment" located in the clinical record was completed on 10/3/2017. The assessment included, "...Pt (patient) reviewed for annual assessment during care plan meeting today...PO intake: 75-100%, Diet: Regular...Height: 68 inches...Weight 198.4 pounds...Estimated nutritional needs: Calories: 2009-2163 kcal...Protein: 88-97 Grams...Fluid: 2631 ml (milliliters)..."

Resident #148's CCP (comprehensive care plan) included the following regarding nutrition. "Focus:

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(Name) Resident #148 is at nutrition risk r/t (related to) CVA, dementia with behaviors. Has hx (history) of wt (weight) refusal. (-) wt loss. pressure wound. (sic) Created on: 08/21/2015 Revision on: 04/16/2019. Goal: Will avoid significant weight change through next review. Created on: 08/21/2015 Revision on: 04/18/2019 Target Date: 07/15/2019 Interventions: Encourage healthy snacks and drinks between meals. Created on: 07/13/2017 Revision on: 02/08/2019. Provide diet as ordered. Monitor intake and record each meal. Offer substitute when intake less than 50%. Created on: 08/21/2015 Revision on: 02/08/2019. Weights and labs as ordered. Created on: 08/21/2015 Revision on: 02/08/2019."

Two CMP (complete metabolic panel) labs were noted in the record. The first CMP was dated 12/22/2018 and included, "...Protein, Total 6.2 g/Dl, Reference Range 6.6-8.7, Flag L (low), Albumin, Serum 3.7 g/Dl, Reference Range 4.0-5.0, Flag L (low)..."

The second CMP was dated 02/25/2019 and included, "...Total Protein 5.6 g/Dl, Reference Range 6.0-8.7, Flag L (low), Albumin 2.7 g/Dl, Reference Range 3.5-5.2, Flag L (low).

A Nutrition/Dietary Note dated 12/11/2018 included: "...has a strong appetite with 76-100% PO (oral) intake. His weight is stable...He is receiving a regular diet without supplements..."

A Weight Warning note dated 3/6/2019 included: "WEIGHT WARNING: Value: 168.8, Vital Date: 03/04/2019, -5% change [5.2%, 9.2], -7.5% change [8.1%, 14.8], Weight Committee Meeting, PO Intake: variable, 25-100%, Diet: Regular...,

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Supplement: none, Pertinent Meds: none...has lost wt (weight) r/t (related to) recent hospital visit with c-diff. Resident has AMS (altered mental status), which can also contribute to varied PO intake. Will add medplus QD (everyday) until weight or PO intake stabilizes..."

A Nutrition/Dietary Note dated 4/16/2019 included: "...has unstageable pressure wound to left heel. Pt has CKD (chronic kidney disease), with recent labs indicative of CKD 2. D/t (due to) poor to variable PO intake with wt loss, will add prostat AWC QD to promote wound healing at this time..."

The most recent "Malnutrition Universal Screening Tool" dated 4/16/2019 included, "...Most Recent Weight 154.8 on 4/15/2019...Unplanned weight loss in past 3-6 months 2. >10%...Comments: Resident has variable intake, 0-100%. Pt. receiving medplus and prostat to promote intake and weight stability. Labs reviewed. Meds reviewed. Pt has pressure wound to heel..." This screening was signed by the Dietetic Technician.

Physician Progress Notes dated 4/1/2019 and 4/16/2019 included: "...4/1/2019...Today nursing requests I see the patient for reports of loose, mucousy stools. He has a hx (history) of recurrent C. difficile colitis, was most recently taking oral vancomycin 10 days ago. However, the nurse on duty today states he has had no further loose stools since the weekend. A stool sample was never collected due to this...Past Medical History: C-diff colitis and Sepsis-hospitalization- 2/2019...Plan: ...Will continue to closely monitor going forward...Continue other current orders, treatments, and medications."

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Progress Note dated 4/16/2019 included: "...seen today to review a wound that was noted on his left heel...Review of Systems: General: ...the resident does complain that his left heel is uncomfortable. Especially when I am removing the bandages and touching around the eschar...Plan: ...We will continue to follow..."

On 05/02/2019 at 9:48 a.m. the Dietetic Tech was interviewed regarding Resident #148's weight loss and lack of interventions. She stated, "I added large portions on April 2nd in meal tracker, but forgot to document it in PCC (point click care). I added Prostat. I didn't add protein shakes or anything because it is such a large amount. We do have weight meetings. I take notes during the meetings and then record in PCC later."

At 12:15 p.m. on 05/02/2019, the Corporate RD (Registered Dietitian) was interviewed during a meeting with the survey team. The Corporate RD stated, "I have been here since September 2018. I am not familiar with him (Resident #148). May I look at his record and get back with you? I am consulted for high risk, for example, weight loss, dialysis, tube feeders, abnormal labs. I have not received a consult on him to my knowledge."

LPN #9 (licensed practical nurse) was interviewed on 05/02/2019 at 3:00 p.m. regarding Resident #148's supplements, Medplus and Prostat. "I give them with his morning meds in separate cups and then sign them off on the MAR (medication administration sheet)."

At 3:15 p.m. the Corporate RD entered the conference room and provided copies of old nutrition assessments that had been completed

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on Resident #148. The most recent assessment was dated 10/3/17. The RD stated, "I completed an assessment today. His po intake varies, but with the supplements we've added we are meeting his nutrition needs. I am not certain that the place on his heel is from his nutrition. He had booties on his feet. He has had a lot going on with his C. diff. and other diagnoses." The Nutrition/Dietary Note dated 5/2/2019 at 1400 (2:00 p.m.) included, "Note Text: RD f/u (follow up) for wound/wt loss: (Name) Resident #148 was referred to this writer for follow up regarding wound to (L) heel and possible significant wt loss. Resident is currently on regular diet w/large portions. PO intakes vary, average 26-50%. Resident is also on Med Plus 2.0 4 oz QD to help increase po intakes and promote wt stability and Pro Stat AWC 1 oz QD...Resident with significant wt loss noted x 3 mos and 6 months. Wt stable x 1 mo...Estimated nutrition needs: 2485-2840 kCals, 75-78 g pro, 2130-2485 mLs...Add to weekly weights. Encourage at meals, provide assistance as needed...Current diet, Med Plus and Prostat provide 2713 kCals and 117 g protein, which meet estimated needs. Continue POC (plan of care), will monitor and assess as needed"

CNA #2 was interviewed at 6:10 p.m. on 05/02/2019 regarding Resident #148's dietary habits and needs. CNA #2 stated, "In the morning you aren't going to get a good meal in him. Doesn't like to wake up. He will drink his coffee. For lunch he does pretty well. We get him up in the chair and he is more alert. In the evenings, it just depends on his mood. He is easily distracted, focuses on one thing at a time. We try to cue him, but he doesn't like people feeding him. He becomes agitated. He doesn't

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ask for snacks and usually declines when offered."

CNA #13 was interviewed at 6:15 p.m. on 05/02/2019. "I have him tonight. He didn't eat his fish, but ate everything else. I asked if he wanted a sandwich and he said no. I did not need to cue him to eat. We set his tray up, cut up his meat and then he eats."

RN #2 was interviewed at 6:18 p.m. on 05/02/2019 regarding Resident #148. RN #2 stated, "If he is not eating, the CNA's will sit with him and cue him. He won't let the aides feed him. He goes through cycles where he is very sleepy and won't eat. He does much better when he is up in the chair. (Name, CNA) a 3-11 CNA on that unit does well with him. He says sometimes around 10:00 p.m. or so he will eat all kinds of stuff, as sandwich and snacks and by morning he is back to not eating."

The Administrative team was advised of the above findings during a meeting with with survey team on 05/02/2019 at 7:30 p.m. No further information was received prior to the exit conference.

2. Resident #50 was admitted to the facility on 12/22/16. Diagnoses for this resident included, but were not limited to: Alzheimer's dementia, colostomy, malaise, wandering, dementia with behavioral disturbances, and polyosteoarthritis.

The most current MDS (minimum data set) was a quarterly assessment dated 02/23/19. This MDS assessed Resident #50 as a 9 cognitively, indicating the resident had moderate impairment in daily decision making skills. The resident was assessed as requiring supervision with at least

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one staff person assist for meal consumption.

Resident #50's annual MDS assessment dated 11/23/19 was reviewed for comparison and documented the same cognitive score. The resident was assessed as being independent with set up only for meal consumption.

Resident #50 was observed in the dining room on 04/30/19 tat approximately 12:30 PM. Resident #50 was sitting at a table with three other residents. Resident #50 was served a lunch tray that included mashed potatoes. The resident was observed eating the mashed potatoes with her fingers and not using eating utensils. No staff prompted or assisted the resident. A CNA (certified nursing assistant) was informed and the CNA stated, "...she does that."

On 05/01/19 the resident was observed in bed for breakfast and lunch.

On 05/02/19 at approximately 7:50 AM, Resident #50 was observed alone in her room, eating a half sandwich on her bedside table. Resident #50 was observed to take a bite and then took the sandwich apart and laid it on the bedside table; the resident had a carton of whole milk on the bedside table. Resident #50 consumed only part of the sandwich.

At approximately 8:25 AM, Resident #50 was observed again, alone in her room, sitting with the bedside table in front of her. The resident had a breakfast tray in front of her. The resident had bacon and scrambled eggs, with additional breakfast items. The resident also had a carton of fat free milk, in addition to the whole carton of milk (from the previous observation). Resident

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#50 took a bite of bacon and put it down, then picked up her milk and sat it down and then attempted to eat scrambled eggs with her hands. Resident #50 did not have assistance, prompting or oversight from staff during this time.

Resident #50's physician's orders were reviewed and documented, "...Regular diet Level 7-Regular texture, Regular liquids consistency...Med Plus 2.0 three times a day to promote weight stability 4 oz..."

Resident #50's CCP (comprehensive care plan) was reviewed and documented, "...ADL self-care deficit...Eating: The resident is able to feed self after set up [revision on: 05/08/18]...Resident has impaired cognitive function...thought process...cue, reorient and supervise as needed...Nutritional risk due to...dementia...behaviors...avoid significant weight change...administer medications...labs as ordered...monitor...appears concerned during meals...provide, serve diet as ordered. Monitor intake and record every meal. Provide supplement as ordered...weights as ordered..." All of these interventions were dated 12/22/16 with a revision and added weights as ordered on 01/04/17.

On 05/02/19 at approximately 10:30 AM, the dietary tech was interviewed regarding Resident #50 and interventions put in place to prevent weight loss. The dietary tech stated that Resident #50 has supplements. The dietary tech was asked how she ensured the resident got the 4 ounces of supplement. The dietary tech stated that she had to trust the nurses are giving it. The dietary tech was asked how she ensured the resident was getting enough supplement. The

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dietary tech was made aware that there was no documentation regarding the amount consumed by the resident. The dietary tech stated, "I see what you are saying, how much is consumed..." The dietary tech stated that Resident #50 also gets a magic cup. The dietary tech was made aware that was not on the resident's orders or in the resident's care plan, and was asked where that would be documented. The dietary tech stated that supplements are included with meal consumption as a whole and are not separate. The dietary tech was asked how she knew if the resident consumed the supplement if it was in with the meal. The dietary tech did not respond. The dietary tech was asked to provide assessment information for Resident #50 for the resident's estimated nutritional needs. The dietary tech stated that she does not do that, the RD (Registered Dietitian) does. The dietary tech was asked for assistance in locating the most recent nutritional assessment for Resident #50.

The resident's weight change notes were reviewed and documented the following:

10/31/19 "...has a strong appetite and is consuming 51-100% consumed 100% of sandwich with RD as snack, had to remind her that she had a sandwich...confusion makes resident inappropriate to interview, weight stable..."

11/29/19 "...good appetite with 51-100%...dementia...potentially effect her weight...due to being distracted, forgetting to eat, or not being in room when food arrives...wanders...very active...she has lost some insignificant weight....would like her weight to stabilize..."

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01/10/19 [LATE ENTRY] "...Value: 111.1...-10% change...Med Plus BID...wanders frequently...easily distracted from her meals...CNA's encourage her to continue eating and often has to redirect her to consume all of her meals...increase medplus to TID...add magic cups to lunch and dinner..."

02/07/19 "...Value 107.8..."

03/07/19 "...Value 105.0...has lost likely related to dementia...frequently active in the building...easily distracted from eating...needs constant cueing at meals to eat all of the food provided...will add magic cup BID to promote weight gain..."

05/01/19 "...medplus TID and magic cup BID...despite additional supplements pt continues with dementia...frequently distracted during meals...recommend house shakes with meals..."

The dietary tech presented a Nutrition assessment dated 12/26/16. This assessment documented that the resident's weight on 12/23/16 was 136.5 and documented the resident's caloric needs as 1600-1800 calories. The assessment documented that the patient was a nutritional risk due to dementia.

On 05/02/19 at approximately 1:00 PM, a meeting was held with the DON, administrator, corporate nurse, RD and dietary tech. The facility staff were made aware of Resident #50's significant weight loss and concerns that the resident has not been provided appropriate assistance, after it has been identified and documented that the resident needs much encouragement, prompting and supervision. The facility staff were also made

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aware of the lack of accurate accounting of supplements for Resident #50. The RD was asked if she was aware of this resident's weight loss. The RD stated, that she was not informed of this resident's weight loss or of any concerns for this resident.

No further information and/or documentation was presented prior to the exit conference on 05/02/19 at 8:30 PM to evidence that this resident was provided adequate interventions and assistance to maintain acceptable weight parameters.

3. Resident #92 was admitted to the facility on 02/20/08 originally and readmitted on 12/31/09. Diagnoses for Resident #92 included but were not limited to: high blood pressure, DM (diabetes mellitus), cellulits, CKD (chronic kidney disease), edema, chronic pain, osteoporosis, and anemia.

The most current MDS (minimum data set) was a quarterly assessment dated 03/24/19. This assessment documented the resident with a cognitive score of 15, indicating the resident was cognitively intact for daily decision making skills. The resident was independent for meal consumption.

Resident #92's weight records documented the following in pounds:

10/01/18- 205.0
11/01/18- 189.8
11/26/18- 182.9
12/04/18- 176.9
01/28/19- 172.9
02/25/19- 170.1
03/25/19- 163.5

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F 692	Continued From page 78 04/29/19- 163.7 Resident #92 lost 41.3 lbs or 20.15% over six months. On 05/01/19 10:25 AM, Resident #92 was interviewed and stated that she has lost a lot of weight. Resident #92 stated that some food she doesn't like and some food she can't eat, because she doesn't like it. The resident's current physician's orders were reviewed and documented, "Regular diet Level 7-Regular texture, regular liquids consistency." The resident's current CCP was reviewed and documented, "...ADL self-care performance deficit...EATING: Provide tray setup. Encourage resident to feed self independently [created: 09/22/14] [Revision: 07/15/18]...is at nutritional risk...DM...edema...potential for significant weight loss changes...[created: 09//16/14] [revised: 05/01/19]...administer medications [03/05/15]...labs as ordered...provide, serve diet as ordered, monitor intake and record every meal...RD to evaluate and make diet change recommendations [09/16/14]...weights as ordered [created/revised: 03/05/15]..." Nutritional notes were reviewed for this resident and documented the following: 11/08/18 "Weight change note...Value 189.4...she was happy with weight loss. Discussed importance of losing weight through healthy choices instead of unintentional weight loss...does not appear to have weight change or change of condition, medication or fluid changes present...question scale accuracy...will do weekly	F 692		

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weights for next month..."

11/29/18 "...has lost 6.5 lbs this week. She has a strong appetite...not open to supplements...weight loss appears legitimate...appetite is good and she has ate as usual without changes...unit manager requested MD [medical doctor] to see for unusual weight loss with no clinical evidence to explain..."

Physician's progress note dated 11/30/18 documented, "...no appetite loss, nausea, vomiting, diarrhea, constipation, or abdominal pain...well developed and well nourished..." Weight loss is not mentioned in this progress note.

12/20/18 "...Value: 177.3...has lost weight over the past 3 months...believes weight loss is related to pneumonia she had in September, although most weight loss occurred post PNA [pneumonia]...appears slimmer in the face, shoulders and legs...is pleased with her weight loss...will not add supplement at this time as gradual weight loss is desirable...not interested in supplements..."

A physician's progress note dated 12/03/18 documented, "...no significant weight change...abdomen soft, nontender, nondistended...no palpable masses noted..." No other information was documented regarding weight loss or nutritional concerns.

Physician's progress note dated 12/27/18 documented, "...reports an approximate 25-30 pound weight loss since September...confirmed by her weight record...she reports sometimes she asks for things, as she can pick her own diet, and

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they are no longer available...appetite is lower...she feels that her appetite is decreased and her stomach has 'shrunk in size'...will talk to dietitian to see if she can stop by...favorite foods and get them to her..."

There was no documentation that the above was competed.

01/10/19 [LATE ENTRY] "...Value: 175.1...has had consistent weight loss since October 2018...weekly weights...weight has not stabilized...loss is beneficial...encourage...healthy, balanced meals..."

02/13/19 "...Value: 175.3...lost a significant amount of weight 10/1 -11/1 15.2 lb...weight loss was related to increased lasix...desirable ...related to pneumonia that caused poor intake [documentation reveals resident had pneumonia in Sept 2018]...declined nutrition supplements..."

The resident had lasix 60 mg ordered since July of 2018. The resident did receive additional doses during the month of September and October.

02/26/19 "...Value: 170.1...patient experienced out of facility weight loss, no acute loss or changes..."

There was no information in the resident's record to indicate that the resident was out of the facility during any time from October 2018 through May 2019.

03/07/19 "...weight change...decline in appetite...declines supplements..."

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04/10/19 "...no nutritional intervention at this time due to pt refusal of supplements or large portions..."

04/30/19 "...resident willing to try various supplements...agreed to house shakes twice a week..."

Resident #92 was interviewed on 05/02/19 at approximately 8:00 AM. Resident #92 stated that a CNA (certified nursing assistant) told her that she needed a weight for the first of May and gave her a chocolate milk shake, vanilla pudding, and a glazed donut. Resident #92 stated that the diet technician came and saw her and asked what she would like for breakfast and a menu was completed. The resident stated that diet technician told her she could have a big cinnamon roll, scrambled eggs, sausage and milk. Resident #92 stated that she told her she wanted the cinnamon roll and a piece of sausage. The resident then stated that the diet technician told her she could have two cinnamon rolls and if the facility has danishes she could have two, and if the facility has donuts, she could have two. Resident #92's meal tray came shortly later and there were two cinnamon rolls and a piece of sausage, along with a carton of fat free milk.

The diet technician was interviewed on 05/02/19 at 10:30 AM, regarding the inconsistency of the above notes for Resident #92 for lasix, being out of the facility, and pneumonia that the resident had in September 2018. No comments were made. The diet technician stated that nothing was put in place for this resident until yesterday and that the resident was told in the past that it isn't safe to lose weight this fast. The diet

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technician stated that the resident was tried on Med Plus and that she didn't like it. The diet technician was made aware that the documentation did to reflect that. The diet technician stated that the resident agreed yesterday to have some shakes and her dietary preferences were updated as well.

On 05/02/19 at approximately 1:00 PM, a meeting was held with the DON, administrator, corporate nurse, registered dietitian (RD) and diet technician. The facility staff were made aware of concerns for Resident #92's significant weight loss and concerns that the resident has not had a full nutritional assessment and/or other interventions implemented for this resident. The facility staff were made aware that the resident had fat free milk. The RD was asked if she was aware of this resident's weight loss. The RD stated that she was referred to her at the end of April and stated that she saw the resident today. The RD was asked for the most current nutritional assessment for this resident.

At approximately 3:00 PM, the RD presented a complete nutritional assessment on this resident from 07/13/16 and stated that was all she had or could find for Resident #92. The resident's weight was documented as 200.0 lbs at that time. The RD stated that she found out about the skim (fat free) milk and stated that unless a resident requests or staff enter something other than fat free milk into the system, all residents will get fat free milk. The RD stated that fat free milk is the default.

A policy was requested on weight loss procedures or protocols at that time.

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The DON (director of nursing) presented the facility policy, "Weight Monitoring and Tracking...Effective Date: 09/20/18" to this surveyor at 4:10 p.m. on 05/02/2019. The policy included, "Policy: The Center has a system in place to weigh, monitor, and track patient's weights on a timely schedule. Weights are tracked and monitored by way of the interdisciplinary Weight Variance Committee. Procedure: 1. The Director of Nursing is responsible for ensuring patients are weighed in a timely manner using proper technique. Nursing staff is responsible for recording weights in the patient medical record. 2. An electronic system will be utilized for recording, tracking, and reporting weights and weight variances. 3. All patients will be weighed on admission/readmission and weekly x 4 weeks, or until the interdisciplinary team determines weight is stable, then monthly thereafter if weight is stable...10. Patients being followed by the committee for weekly weights may meet one or more of the following criteria: Significant unplanned weight loss; New or re-admissions for 4 weeks or until stable; ...Identified trends in weight change; ...Patients with pressure ulcers or wounds for 4 weeks or until stable...Best Practice Guidelines and Protocols for Unplanned Significant Weight Change: Step One: When significant unplanned weight change occurs...Document unplanned significant weight change and update the care plan. Review meal intake record and estimate % intake vs. estimated needs. Visit patient: update and honor food preferences. Recommend appropriate nutrition intervention: Liberalize diet to increase calories, protein and/or fluid, Increase serving sizes, Add snacks, supplements, multivitamins/minerals. Provide adequate

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F 692	Continued From page 84 assistance to maximize food, fluid, snack and supplement intake...Discuss and document collaborative efforts with Weight Committee..." No further information and/or documentation was presented prior to the exit conference on 05/02/19 at 8:30 PM to evidence that this resident was referred to the RD, or that the resident's diet was liberalized or appropriate supplements were provided to maintain weight parameters for Resident #92.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure oxygen was administered as ordered by the physician for one of 38 residents, Resident #152. The physician ordered for Resident #152 to have oxygen at 2 LPM (liters per minutes) and it was observed at 4 LPM. Findings included: Resident #152 was admitted on 04/09/18. Diagnoses for this resident included, but were not	F 695	F 695 Resident #152 is receiving oxygen as ordered at 2LPM. Residents with current orders for oxygen were reviewed to ensure accuracy of delivery. Current nursing staff educated regarding accurate administration of oxygen per physician order.	6/4/19

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F 695	Continued From page 85 limited to: COPD (chronic obstructive pulmonary disease), heart failure, high blood pressure, history of acute and chronic respiratory failure with hypoxia, dementia, and anxiety disorder. The most current MDS (minimum data set) for this resident was an annual assessment dated 04/15/19 documented that the resident had a cognitive score of 4, indicating the resident was severely impaired for daily decision making skills. The resident triggered in Section O [Special Treatments, Procedures, and Programs] C. Oxygen therapy, as receiving oxygen while a resident. Resident #152 was observed on 05/01/19 at 08:40 AM with oxygen (O2) at 4 LPM (liters per minute) via nasal cannula. The resident was laying in bed with the head of the bed at approximately 20 degrees. The resident was observed again on 05/02/19 at 11:11 AM laying in bed with the head of the bed at approximately 10 degrees with O2 via nasal cannula 4 LPM. The resident's current physician's orders were reviewed and documented, "...Oxygen at 2L Via NC every shift for COPD..." On 05/02/19 at 11:13 AM, an interview with licensed practical nurse (LPN) #10 was conducted regarding the above observations of Resident #152 being on 4 LPM on two separate occasions, on two separate days. LPN #10 stated that she didn't know what the resident's O2 was supposed to be set to without looking. LPN #10 was made aware that it was 2 LPM, but was asked to check for verification. LPN #10 checked	F 695	10 residents with oxygen orders will be audited weekly x 6 weeks to insure accurate delivery of oxygen. Process will be reviewed in quarterly QA meeting.	

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F 695	Continued From page 86 and stated that, "Yes, it is 2 LPM." LPN #10 stated that the O2 is supposed to be checked by everyone and did not know who may have set it on 4 LPM. The resident's CCP (comprehensive care plan) documented, "...administer oxygen as ordered and resident can tolerate/allow...promote lung expansion and improve air exchange with proper body alignment, elevate head of bed as tolerated..." On 05/02/19 at 11:47 AM, LPN #3 (Unit Manger) was interviewed regarding the above observations of Resident #152. LPN #3 stated that there was nothing that would warrant her [the resident's] oxygen to be changed or increased and isn't sure how or why that happened. On 05/02/19 at approximately 12:30 PM, the administrator, DON (director of nursing) and corporate nurse were made aware in a meeting with the survey team. No further information and/or documentation was presented prior to the exit conference on 05/02/19 at 8:30 PM.	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care	F 725		6/4/19

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F 725	Continued From page 87 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on resident interview, family interview, a resident group interview and staff interview, the facility staff failed to respond to call bells in a timely manner. Residents, the resident council group and family interviews reported lengthy call bell response with waiting at times up to 1 hour for staff response. The findings include: On 4/30/19 at 11:30 a.m., Resident #33's family member was interviewed about quality of life and care in the facility. The family member stated call bell response was slow at times. The family member stated she waited up to thirty minutes on occasions for staff to respond. On 4/30/19 at 2:00 p.m., Resident #133's family	F 725	F 725 Resident #133 and #64 call bells are now being answered in a timely manner. Current residents were observed to ensure timely answering of call lights. Issues were addressed at the time of observation. Current staff educated on timely response to call lights to ensure patient safety and wellbeing. Audit will be conducted daily and include weekends by nursing for 6 weeks for call light answering compliance. The DON will	

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member was interviewed. The family member stated the family was "short-staffed" on weekends with the evening shift especially slow. The family member stated she waited on one occasion for 40 minutes for staff to come and assist her mother to bed. The family member stated she activated the call bell recently and waited one hour for someone to come. The family member stated she finally went to the nursing desk to get someone and found several staff members talking and using a cell phone.

On 4/30/19 at 3:45 p.m., Resident #64 was interviewed about staffing and call bell response. Resident#64 stated call light response was slow, especially on the third (night) shift. Resident #64 stated she had been placed on the bedpan and waited up to 45 minutes for staff to return. Resident #64 stated she had experience several "accidents" waiting for staff to get her on the bedpan. Resident #64 described the incontinence accidents as "embarrassing."

On 5/1/19, a group interview was conducted at 1:30 p.m. with seven cognitive residents in attendance. Residents in the group meeting were asked about call bell response time in the facility. Comments from the group included:

"I have waited up to 2 hours for someone to come and help me get untangled in the bed (not the bedrails)."

"They [CNA] will come in the room, ask what you want, tell you they will be right back and then they don't come back."

"I think we say they are short-staffed, but we see them sitting around talking and sometimes on

meet with Resident council and any Resident and family that will want to attend, to address issues x 1 time a week for 6 weeks.

Process will be reviewed in quarterly QA meeting.

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F 725	Continued From page 89 their cell phones, so really, it isn't known if they don't have enough help or they are just not doing what they should." "The CNA will say, 'I have to help this other resident and can't help you right now.'" On 5/2/19 at 7:40 a.m., the licensed practical nurse unit manager (LPN #7) was interviewed about call bell response on her unit. LPN #7 stated all staff were supposed to respond when call bells were activated. LPN #7 stated staff responding were to either address the issue or seek appropriate help to meet the need. LPN #7 stated staff members were expected to respond to call bells within 3 minutes. On 5/2/19 at 8:50 a.m., the administrator was interviewed about call bell response in the facility. The administrator stated, "We want staff to answer call bells in 5 minutes or less." The administrator stated he was aware of resident and family complaints about lengthy call bell response. The administrator stated the lengthy response had been recognized. These findings were reviewed with the administrator and director of nursing during a meeting on 5/2/19 at 12:20 p.m.	F 725		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including	F 757		6/4/19

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F 757	Continued From page 90 duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure one of 38 residents were free of an unnecessary pain medication, Resident #50. Resident #50 had an orthopedic consult ordered on 01/07/19 after a fall, and to date [05/02/19] the consult has not been completed. Resident #50 has been being treated with opioid pain medications from 01/09/19 to date [05/02/19] almost on a daily basis. Findings included: Resident #50 was admitted to the facility on 12/22/16. Diagnoses for this resident included, but were not limited to: Alzheimer's dementia, colostomy, malaise, wandering, dementia with behavioral disturbances, and polyosteoarthritis. The most current MDS (minimum data set) was a	F 757	F 757 Resident #50 has been evaluated by physician for increase use of opioid pain medication and has been sent to ortho MD for consult and evaluation. Current residents with opioid pain medication reviewed to ensure appropriate use and duration of medication. Current licensed staff will be educated regarding unnecessary drugs to include excessive duration and adequate indication for use of opioid pain medication. Pharmacist will conduct regimen reviews to ensure unnecessary meds are identified. Pain medication administration	

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F 757	Continued From page 91 quarterly assessment dated 02/23/19. This MDS assessed the resident as a 9 cognitively, indicating the resident had moderate impairment in daily decision making skills. The resident was additionally assessed as requiring extensive assistance for dressing, toileting, and hygiene. The resident was assessed as having pain occasionally, with a numeric score of 4 (scale 1-10), no verbal descriptors indicated. No other pain assessment information was documented. The resident's annual MDS assessment dated 11/23/19 was reviewed for comparison and documented the same cognitive score. The resident was assessed as requiring limited assistance with at least one person for bed mobility, transfers, and toileting. This MDS documented the resident had no pain. During clinical record review, it was documented in a nursing note dated 01/06/19 [3:52 PM] that the resident had a "possible" fall on 01/05/19 with bruising and swelling to the left arm and left hip. According to the documentation x-rays were ordered and upon further assessment the resident had worsening deformation and dislocation of left wrist and left elbow. An order was obtained to send the resident out to the ED [emergency department] for evaluation. A change of condition note dated 01/06/19 [3:58 PM] documented that the resident had uncontrolled "fall" pain. A nursing note dated 01/06/19 [10:36 PM] documented that the resident returned back to the facility at 7:30 PM with negative findings and negative X-rays. The nursing note documented that the resident continues with swelling and	F 757	control sheets will be audited 2 times a week for 6 weeks and matched with emar for accuracy of time administration and for non-pharmacological intervention prior to administration. If excessive duration is identified then physician will be notified for adjustments to medication regimen. Process will be reviewed in quarterly QA meeting.	

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bruising with deformity of left forearm/wrist and that a house physician was currently in the facility who assessed the resident and ordered stat X-rays of the left wrist for pain and deformity; X-ray completed.

A radiology report for examination date 01/06/19 [9:27 PM] was reviewed and documented, "...Reported date: 01/07/19 1:30 AM...ulna rod is noted with its distal tip extending beyond the ulnar. Distal aspect of ulna and radius is surgically absent cortex...no acute fracture. 2nd rod is noted in soft tissues lateral to ulna. Wrist is deformed...caudal migration of carpal bones...soft tissue swelling....osteopenia...no acute fracture...Recommend orthopedic consult, 2nd rod is noted in soft tissues lateral to ulna. Markedly limited evaluation since 2 images of lateral view only was provided..."

Nursing notes documented the following events:

01/07/19 [8:43 AM] "....unwitnessed fall on 01/05/19....observed resident sitting on floor...got self up off floor...pain continued to be uncontrolled...sent out to ED...had X-rays completed all negative...[name of physician] in facility...assessed injuries...ordered stat X-ray...uncontrolled pain...no acute fx...There is a recommendation that resident have an ortho consult..."

A physician's order dated 01/07/19 documented for the resident to have an orthopedic consult related to possible dislocation of the resident's left arm/wrist.

A physician's order for Tramadol 25 mg [milligrams] was ordered on 01/09/19 for

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moderate to severe pain.

A nursing note dated 01/15/19 documented that the resident was still having "...Resident continues with discoloration and rod displacement to LUE [left upper extremity] s/p [status post] recent fall..."

Resident #50's clinical records were reviewed and did not reveal that the physician's ordered orthopedic consult was completed.

The resident's MAR's (medication administration records) were reviewed for January, February, March, April, and May of 2019. The MARs revealed the following:

January 2019: The resident received Tramadol 25 mg a total of 38 times from 01/09/19 [order date] through the end of the month 01/31/19. The resident received Tylenol 650 mg a total of 10 times from 01/09/19 through 01/31/19.

February 2019: The resident received Tramadol 25 mg a total of 36 times for the whole month of February. The resident received Tylenol 650 mg a total of 3 times for the entire month of February.

March 2019: The resident received Tramadol 25 mg a total of 50 times during this month and received Tylenol 650 mg a total of 9 times for the month.

April: The resident received Tramadol 25 mg a total of 46 times and Tylenol 650 mg a total of 2 times for the entire month.

May 2019: The resident received Tramadol 25 mg a total of 4 times from May 1st and May 2nd.

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The resident did not receive any Tylenol 650 mg on those days.

The resident's current CCP (comprehensive care plan) was reviewed and documented, "...Resident had an actual fall...will resume usual activities without further incident...cardiovascular referral...monitor changes in behavior...vital signs as needed...Pain [created on 12/22/16] related to osteoarthritis...history of compression fracture...will have no/ decreased complaints of pain...encourage relaxation techniques and provide diversional activities...repositioning, relaxation...heat/cold...to relieve pain... prior to medicating per...order...[created on: 12/22/16 revised on: 04/27/17]...medicate as ordered [created on: 12/22/16]...notify MD for pain not relieved with medication or new complaints of pain...pre-medicate for painful procedures [created on 12/22/16]..."

Nursing notes were reviewed and did not reveal that the resident was provided non-pharmacological interventions prior to medicating with pain medication as documented in the resident's CCP.

A physician's progress note dated 03/04/19 [written by a PA-C] documented, "...seen only 1/9 since her last...exam secondary to a unwitnessed fall and decreased activity for several days...emergency room...concern for dislocation of a rod in her right arm. She was to have follow up with orthopedics. I would like to check this...memory, judgement, insight severely impaired...Nursing reports Tramadol PRN given at the beginning of the day has been helpful..."

A physician's progress note dated 04/11/19

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[written by a PA-C] documented, "...had a fall within the last several months, decreased activity, there was some concern for dislocation of rod in her right arm...I do believe she did go to orthopedic follow up for this...we will continue to follow closely..."

A physician's progress note dated 04/30/19 [written by a PA-C] documented, "...severe dementia...Continue to implement Tramadol for agitation to assess if pain is part of the picture...We will continue to follow up with scheduling as well s nursing unit manager about status of her orthopedic consultation for the possibility of a dislocated rod in her right arm..."

On 05/01/19 at 4:15 PM, the survey team met with the DON (director of nursing), administrator and corporate nurse consultant and they were made aware of concerns regarding the above information and asked for assistance in locating the physician orthopedic consult.

On 05/02/19 at 9:00 AM, an interview with LPN #3, who was the UM (Unit Manger) for Resident #50, was conducted. LPN #3 was made aware that there was no evidence of an orthopedic consult for this resident that the physician had ordered and that was recommended by the physician who read the original X-ray report. LPN #3 was made aware that the resident has been receiving Tramadol almost daily and multiple times on some days for pain related to her wrist/arm from a fall that occurred in January 2019. LPN #3 stated that she would look to see if it was done. LPN #3 agreed that the resident should not have been getting this medication for this long and agreed that the orthopedic consult should have been completed to determine if there

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F 757	Continued From page 96 were other alternative treatments for Resident #50. LPN #3 later returned and stated that the orthopedic consult had not been completed and was not sure why. LPN #3 stated that a medication review was now being completed. The survey team met with the administrator, DON and corporate nurse consultant on 05/02/19 regarding Resident #50 not being seen by ortho for a possible dislocated rod in her arm, and that staff were continually treating this resident with opioid pain medication for months. The facility staff were made aware that the physician's order was written on January 7th, 2019 for an orthopedic consult, and almost 4 months later, the resident still has not been seen. The facility staff were made aware that this resident was and has been being treated with an opioid pain medication, almost daily, multiple times daily on some occasions, and that Resident #50 was not given non pharmacological interventions or administered Tylenol 650 mg (non addictive pain analgesic) prior to administering the opioid pain medication on numerous occasions, as evidenced on the resident's MARs, physician's orders and the resident's CCP [comprehensive care plan]. No further information and/or documentation was presented prior to the exit conference on 05/02/19 at 8:30 PM to evidence that this was not an unnecessary medication for an extended duration for Resident #50.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		6/4/19

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§483.45(e) Psychotropic Drugs.
§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their

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F 758	Continued From page 98 rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure one of 38 residents was not prescribed PRN (as needed) psychotropic medication for greater than 14 days, Resident # 34. Resident #34 was prescribed as needed Lorazepam without an end date for the medication. Findings were: Resident #34 was admitted to the facility on 01/18/2018 with the following diagnoses, but not limited to: Cerebrovascular accident, cerebral infarct, dysphagia, falls, and dementia. The quarterly MDS (minimum data set) with an ARD (assessment reference date) of 02/12/2019, assessed Resident #24 as cognitively intact with a summary score of "15". The clinical record was reviewed on 04/30/2019 at approximately 2:00 p.m., to include the physician orders. Observed on the POS (physician order sheet) was the following: "Lorazepam tablet 0.5 MG. Give .5 tablet by mouth every 8 hours as needed for anxiety." The order was dated 03/05/2019.	F 758	F 758 Resident #34 prn psychotropic medication has been evaluated and properly documented and diagnoses addressed and evaluated for proper use after the 14 days since ordered. Current prn Psychotropic medications have been reviewed by pharmacist and nurse for compliance of 14 days discontinue and reevaluation. Licensed staff will be educated to check when administering medication that all psychotropic medication meet federal guidelines by having proper diagnoses for use, gradual dose reduction if indicated and prn psychotropic prn medications requirements are being met. Psychotropic medication currently being used in facility will be audited by nursing weekly and all new admissions will be checked for compliance of 14 day discontinuation and re-evaluation requirements for all prn psychotropic medications for a period of 6 weeks.	

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F 758	Continued From page 99 The MAR (medication administration record) for April 2019 was reviewed. Resident #34 received the PRN Lorazepam 12 times during the month of April. The above information was discussed during an end of the day meeting with the DON (director of nursing), the administrator, the corporate nurse consultant and the ADON (assistant director of nursing) on 05/01/2019 at approximately 4:15 p.m. Pharmacy reviews for the month of April were requested. On 05/02/2019 at approximately 9:00 a.m., the ADON presented information. Included in the information was the pharmacy review from April 2019. The pharmacy did not make any recommendations regarding the use of the PRN Lorazepam. The ADON stated, "Since I have been here we have identified that some of the residents have orders for PRN medications that exceeded the 14 day requirement...we are working to get the orders changed." No further information was obtained prior to the exit conference on 05/02/2019.	F 758	Process will be reviewed in quarterly QA meeting.	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		6/4/19

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F 880	Continued From page 100 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 101 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to develop and implement a water management program to identify the risk of Legionella; and also failed to follow infection control practices for hand hygiene during a medication pass and pour observation and a dressing change observation. 1. The facility staff failed to develop and implement a water management program to identify the risk of Legionella in the facility. 2. Facility staff failed to follow infection control practices for hand hygiene during a medication pass and pour observation. 3. Facility staff failed to follow proper infection control practices during a dressing change for Resident #120.	F 880	F 880 LPN #2 has been educated in proper handwashing, sanitizing area that wound care products will be placed, the changing of gloves from clean to dirty and back to clean with handwashing. Resident #120 is currently receiving wound care per infection control standards of practice. The water management program to identify the risk of Legionella has been developed and implemented. A risk assessment has been completed. Handwashing education provided for current staff. Maintenance staff educated on the water management program to identify the risk of Legionella.	

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F 880	Continued From page 102 Findings include: 1. On 5/2/19 at 3:00 p.m. the DON (director of nursing) was asked for the information on the facility Legionella program. The DON stated the administrator would be the person to speak to. At 3:20 p.m. the administrator, was asked for the documentation of the facility assessment for Legionella and the water temperature management. The administrator stated, "We're getting the policy from corporate about the assessment... I don't know I can say we have the water temps and/or testing here; I really don't know what we have. Let me see what I can find and get back to you." On 5/2/19 at 4:45 p.m. the administrator presented a book titled "Water Management Program" and several pages of water flow diagrams. The book included a policy for a water management program, diagrams of the water flow system, and had several areas marked where temperatures were needed to done in the system. There was no evidence of temperatures taken in locations identified where waterborne bacteria, including Legionella, could grow and spread. There was no risk assessment. The administrator stated "I know the maintenance staff do the room water temps, but that's not what is needed for this [Legionella] is it?" The administrator was informed the water temperatures were needed per the water flow diagram. No further information was provided prior to the exit conference. 2. On 5/1/19 at 7:45 AM, a medication pass and pour was conducted with license practical nurse	F 880	Laminated handwashing guidelines will be placed on every med cart, med room, and in each shower rooms. Med pass and treatment observations conducted for current licensed staff to ensure hand hygiene. Maintenance Director will complete a weekly review of documentation for Legionella risk for 6 weeks and report results to the administrator. Process will be reviewed in quarterly QA meeting.	

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(LPN #2). LPN #2 was observed giving medications to a Resident in the hallway outside of the Resident's room.

After completing medication administration for the Resident, LPN #2 pulled medication out of the medication cart for another Resident. She did not do any hand hygiene after giving medication to the Resident and prior to pulling medications for the next Resident.

LPN #2 dispensed the pulled medications into a medication cup with the exception of a Potassium tablet which was placed into a separate medication cup (both medication cups were placed on the medication cart).

Without conducting hand hygiene, LPN #2 then put on gloves and retrieved the potassium tablet from the medication cup using gloved hands, broke the tablet in half using her hands, and placed the potassium tablet back into the medication cup. LPN #2 then took one medication cup and placed the cup inside the other medication cup resulting in the bottom of the medication cup touching the tablets in the other medication cup.

On 05/01/19 at 4:19 PM, during an end of day meeting with the administrator, director of nursing (DON), assistant DON (ADON) and supervisors, the above information was presented. The ADON verbalized that the nurse should have washed hands between residents and before putting gloves on and not put one medication cup down inside the other.

A policy titled "Infection Prevention & control Policies & Procedures" was obtained that gave

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examples when to use hand hygiene. One example read in part "After any contact with potentially contaminated materials [...]"

No other information was presented prior to exit conference on 5/2/19.

3. Resident #120 was admitted to the facility on 03/23/2019 with diagnoses including, but not limited to: Diabetes, Peripheral Vascular Disease, Parkinson's Disease, Non-Pressure Chronic Ulcer of Left Lower Leg, Stage 4 Pressure Ulcer Right Hip, and Stage 3 Pressure Ulcer of Sacrum.

The most recent MDS (minimum data set) was a 30-day assessment with an ARD (assessment reference date) of 04/20/19. Resident #120 was assessed as cognitively intact with a total cognitive score of 15 out of 15.

On 05/01/2019 at 1:45 p.m. LPN #2 (licensed practical nurse) was observed performing wound care on Resident #120. LPN #2 gathered her wound care supplies and placed them on the bedside table. She did not sanitize the bedside table or place a barrier on the table. She proceeded to wash her hands and don a pair of clean gloves. Resident #120 was already positioned on her left side. LPN #2 removed the gauze packing from the resident's right hip ulcer and discarded. She irrigated the ulcer with normal saline (NS) and patted dry with clean 4x4's (gauze). LPN#2 then took clean gauze, saturated the gauze with Dakin's Solution and squeezed the excess liquid out over the trash can, packed this gauze into the hip ulcer, and covered with a clean dressing. LPN #2 never changed her gloves or washed her hands during the dressing change process, except at the

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beginning. After completing the dressing change to Resident #120's right hip ulcer, LPN #2 removed her gloves, used hand sanitizer, donned another pair of clean gloves, then repeated the same process for the sacral ulcer. Again, LPN #2 did not change her gloves or wash her hands during the dressing change, except at the beginning.

LPN #2 was interviewed at 2:00 p.m. regarding her dressing change procedures. LPN #2 stated, "Yes, normally I wipe the table off. I am just really nervous. No, I didn't change gloves. I never really thought about it. I need to work on that."

At approximately 4:00 p.m. on 05/01/19, the DON (director of nursing) was asked for their dressing change policy. The policy, "General Wound Care/Dressing Changes...Effective Date: 02/01/15" was received at approximately 4:30 p.m. The policy included, "...Procedure: 5. Licensed nurses will follow recognized standards of practice regarding dressing change(s), including date and initials on dressing..." The DON was then asked for a copy of the "Standards of Practice" the facility uses during dressing changes.

On 05/02/19 at approximately 8:00 a.m. the ADON (assistant director of nursing) brought this surveyor the facility hand washing policy. The ADON stated, "I have requested from corporate any specific dressing change policies we may have." The "Handwashing Requirements" policy "Effective Date 12/26/17" included, "...A. Hand Hygiene: 1...j. Before and after changing a dressing...r. After removing gloves or aprons...t. After any contact with potentially contaminated materials (Used wound/treatment dressings)...D.

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Gloves: ...3. Change gloves during patient care when moving from a contaminated body site to a clean body site..."

At approximately 10:00 a.m. the ADON provided a copy of a "Relias Learning" course titled, "About Wound Care: Identification and Assessment." The ADON stated, "This is what corporate has sent me." Included in the learning course on pages 19-20 was the following: "...Cleansing: ...It is important to note that gloves should be changed after the wound has been cleansed and before a new dressing is applied...The goal of cleansing is to remove surface bacteria and debris while minimizing tissue damage to the wound...When cleansing the wound it is important to also cleanse the peri-wound as this decreases microbial counts and promotes healing. For most wounds, you should use saline solution as the preferred cleansing agent because it is an isotonic solution and won't interfere with the normal healing process...Using aseptic technique should be considered if the individual or wound healing are compromised..."

On 05/02/19 at approximately 2:00 p.m., the DON came to the conference room and stated, "We use 'Lippincott' as our dressing change reference." The specific reference was requested. At approximately 2:20 p.m. the DON provided the reference.

Included in the "Lippincott Manual of Nursing Practice , Hand Hygiene, page 843, 1. Hand hygiene is the single most recommended measure to reduce the risks of transmitting microorganisms. 2. Hand hygiene should be performed between patient contacts; after contact with blood, body fluids, secretions, excretions,

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F 880	Continued From page 107 and contaminated equipment or articles; before donning and after removing gloves is vital for infection control. It may be necessary to clean hands between tasks on the same patient to prevent cross-contamination of different body sites..." Page 847 in Box 31-1 "Personal Protective Equipment, Gloves: Gloves are worn to provide a protective barrier and prevent gross contamination of the hands of health care workers; if used properly, they reduce the transmission of microorganisms and help prevent cross-contamination within a patient. Wearing gloves does not replace the need for hand hygiene because gloves does not replace the need for hand hygiene because gloves may be torn during use, and during the removal of gloves, hands may be contaminated. Perform hand hygiene before putting on gloves. Change gloves after contact with infective material, such as feces and wound drainage...Gloves must be changed between procedures on the same patient...wound care..." (1) The Administrator was informed of the above during a meeting with the survey team on 05/02/19 at approximately 7:30 p.m. No further information was received from the survey team prior to the exit conference on 05/02/19. (1) Nettina, S.M. (2019). Lippincott Manual of Nursing Practice (11th Ed.). Philadelphia, PA: Wolters Kluwer.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop	F 883		6/4/19

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F 883	Continued From page 108 policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 883		

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F 883	Continued From page 109 (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure one of 5 resident records reviewed was complete for the influenza vaccine: Resident # 62. Findings include: Resident # 62 was admitted to the facility 3/29/18. A review of the resident's influenza status 5/2/19 at 9:00 a.m. revealed the last influenza vaccine recorded in the clinical record was in 2017. On 5/2/19 at approximately 1:00 p.m. the DON (director of nursing) was asked about the resident's vaccine status for influenza. She stated she would see what she could find. On 5/2/19 at 2:55 p.m. the DON stated "He didn't get it; he 100% should have; he was here in the facility when we were giving flu shots, but he was missed. He should have gotten it." No further information was provided prior to the exit conference.	F 883	F 883 Resident #62 vaccine record up to date and all vaccines that were necessary administered. Education provided to Resident. Current residents were reviewed to ensure flu vaccine offered and documented in vaccine record. Education provided to current licensed staff in administration of vaccines and proper documentation in vaccine record. New admissions will be audited for vaccine status for compliance x6 weeks. Process will be reviewed in quarterly QA meeting.	